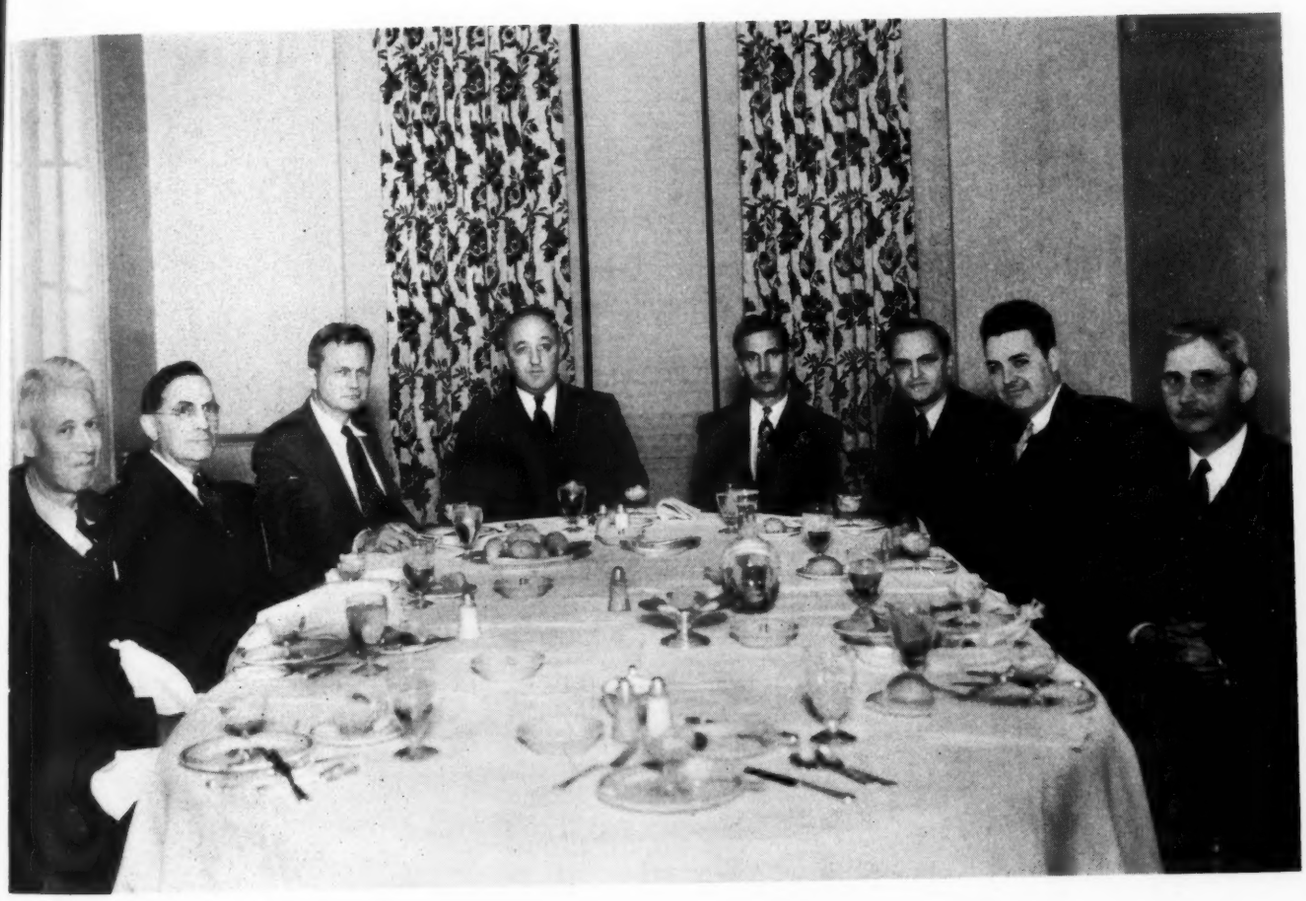
The Journal

of the Michigan State Medical Society

me 51 November, 1952 Number 11

MICHIGAN HEALTH COUNCIL NUMBER



From the Minds of Men —

(See page 1465)

toward a fuller life for epileptics

DILANTIN

DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is supplied in Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1000.

THE JOURNAL
of the Michigan State Medical Society

VOLUME 51 NOVEMBER, 1952 NUMBER 11

Contributors to This Issue

ROBERT J. BANNOW, M.D.

R. J. HUBBELL, M.D.

RAYMOND O. MUETHER, M.D.

J. ARTHUR MYERS, M.D.

RAYMOND D. PRUITT, M.D.

C. E. UMPHREY, M.D.

Table of Contents

THE JOURNAL
of the Michigan State Medical Society

VOLUME 51 NOVEMBER, 1952 NUMBER 11

Office of Publication
2642 University Avenue
Saint Paul 14, Minnesota

Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Secretary and Business Manager of THE JOURNAL
L. FERNALD FOSTER, M.D.
Thorne Bldg., 919 Washington Ave.
Bay City, Michigan

Executive Director
WM. J. BURNS, LL.B.
606 Townsend Street, Lansing 15, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone 57125.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

OFFICERS OF THE SOCIETY
1952-1953

President.....R. J. HUBBELL, M.D.....Kalamazoo
President-Elect.....L. W. HULL, M.D.....Detroit
Secretary.....L. FERNALD FOSTER, M.D.....Bay City
Treasurer.....WM. A. HYLAND, M.D.....Grand Rapids
Speaker.....R. H. BAKER, M.D.....Pontiac
Vice Speaker.....J. E. LIVESAY, M.D.....Flint
Editor.....WILFRID HAUGHEY, M.D.....Battle Creek

THE COUNCIL

WILLIAM BROMME, M.D., Chairman, Detroit
H. B. ZEMMER, M.D., Vice Chairman, Lapeer
L. FERNALD FOSTER, M.D., Secretary, Bay City

	District		Term Expires
ARCH WALLS, M.D.	1st	Detroit	1956
R. S. BREAKEY, M.D.	2nd	Lansing	1955
G. W. SLAGLE, M.D.	3rd	Battle Creek	1955
RALPH W. SHOOK, M.D.	4th	Kalamazoo	1956
J. D. MILLER, M.D.	5th	Grand Rapids	1956
H. H. HISCOCK, M.D.	6th	Flint	1956
H. B. ZEMMER, M.D.	7th	Lapeer	1957
L. C. HARVIE, M.D.	8th	Saginaw	1957
G. B. SALTONSTALL, M.D.	9th	Charlevoix	1957
F. H. DRUMMOND, M.D.	10th	Kawkawlin	1957
C. A. PAUKSTIS, M.D.	11th	Ludington	1953
A. H. MILLER, M.D.	12th	Gladstone	1953
W. S. JONES, M.D.	13th	Menominee	1953
B. M. HARRIS, M.D.	14th	Ypsilanti	1954
D. BRUCE WILEY, M.D.	15th	Utica	1955
W. D. BARRETT, M.D.	16th	Detroit	1955
W. B. HARM, M.D.	17th	Detroit	1953
WILLIAM BROMME, M.D.	18th	Detroit	1954
R. J. HUBBELL, M.D.	President		Kalamazoo
L. W. HULL, M.D.	President-Elect		Detroit
R. H. BAKER, M.D.	Speaker		Pontiac
J. E. LIVESAY, M.D.	Vice Speaker		Flint
L. FERNALD FOSTER, M.D.	Secretary		Bay City
WM. A. HYLAND, M.D.	Treasurer		Grand Rapids
OTTO O. BECK, M.D.	Immediate Past President		Birmingham

EXECUTIVE COMMITTEE OF THE COUNCIL

WILLIAM BROMME, M.D.....Chairman
H. B. ZEMMER, M.D.....Vice Chairman
C. A. PAUKSTIS, M.D.....Chairman Publication Committee
W. S. JONES, M.D.....Chairman Finance Committee
D. BRUCE WILEY, M.D.....Chairman County Societies Committee
R. H. BAKER, M.D.....Speaker, House of Delegates
J. E. LIVESAY, M.D.....Vice Speaker, House of Delegates
R. J. HUBBELL, M.D.....President
L. W. HULL, M.D.....President-Elect
L. FERNALD FOSTER, M.D.....Secretary
WM. A. HYLAND, M.D.....Treasurer

SECTION OFFICERS

Medicine
D. R. Boyd, M.D.....Muskegon
Chairman
C. K. Stroup, M.D.....Flint
Secretary

Surgery
J. M. Wellman, M.D.....Lansing
Chairman
C. L. MacCallum, M.D.....Midland
Secretary

Gynecology and Obstetrics
J. P. Ottaway, M.D.....Detroit
Chairman
J. L. Gillard, M.D.....Muskegon
Secretary

Dermatology and Syphilology
M. G. Butler, M.D.....Saginaw
Chairman
C. J. Courville, M.D.....Detroit
Secretary

Gastroenterology and Proctology
R. L. Fitts, M.D.....Grand Rapids
Chairman
R. M. Burke, M.D.....Detroit
Secretary

Radiology, Pathology, Anesthesiology
W. A. Stryker, M.D.....Wyandotte
Chairman (Path.)
F. K. Wietersen, M.D.....Birmingham
Vice Chairman (Rad.)
E. D. Conner, M.D.....Detroit
Secretary (Anes.)

General Practice
C. J. Williams, M.D.....Grosse Pointe
Chairman
J. W. Rice, M.D.....Jackson
Secretary

Ophthalmology and Otolaryngology
L. L. Loder, M.D.....Muskegon
Chairman (Ophth.)
F. A. Lamberson, M.D.....Detroit
Co-Chairman (Oto.)
L. F. Carter, M.D.....Detroit
Secretary (Ophth.)
R. B. Fast, M.D.....Kalamazoo
Co-Secretary (Oto.)

Pediatrics
P. S. Bradshaw, M.D.....Muskegon
Chairman
H. B. Rothbart, M.D.....Detroit
Secretary

Urology
F. B. Bicknell, M.D.....Detroit
Chairman
B. W. Dovitz, M.D.....Detroit
Secretary

Public Health and Preventive Medicine
J. C. Molner, M.D.,.....Detroit
Chairman
C. A. Neafie, M.D.....Pontiac
Secretary

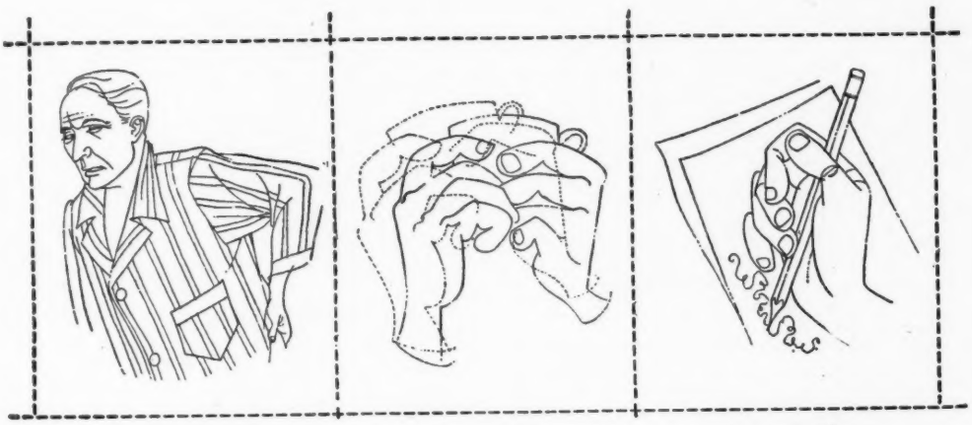
Nervous and Mental Diseases
T. V. Hoagland, M.D.....Detroit
Chairman
K. C. Nickel, M.D.....Grand Rapids
Secretary

DELEGATES TO A. M. A.

Delegates
W. D. Barrett, M.D., Detroit.....1952
W. H. Huron, M.D., Iron Mountain 1952
R. L. Novy, M.D., Detroit.....1952
R. A. Johnson, M.D., Detroit.....1953
W. A. Hyland, M.D., Grand Rapids 1953
J. S. DeTar, M.D., Milan.....1953

Alternates
R. H. Denham, M.D., Grand Rapids 1952
C. I. Owen, M.D., Detroit.....1952
E. F. Sladek, M.D., Traverse City 1953
E. D. Spalding, M.D., Detroit.....1953
W. W. Babcock, M.D., Detroit.....1953
E. C. Texter, M.D., Detroit.....1953

new uniform oral dosage



in muscle spasm of rheumatic disorders | **in acute alcoholism** | **in certain neurologic disorders**

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

Tolserol

Squibb Mephenesin

Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; *Capsules,* 0.25 Gm., bottles of 100; *Elixir,* 0.1 Gm. per cc., pint bottles; *Intravenous Solution,* 20 mg. per cc., 50 cc. and 100 cc. ampuls.

SQUIBB

"TOLSEROL" (REG. U. S. PAT. OFF.) IS A TRADEMARK OF E. R. SQUIBB & SONS

MSMS Committee Personnel

1952-1953

POSTGRADUATE MEDICAL EDUCATION COMMITTEE

H. H. Cummings, M.D., *Chairman* (1955)
Dept. PG Med., Univ. Hosp., Ann Arbor
E. I. Carr, M.D., *Vice Chairman* (1955)
300 W. Ottawa, Lansing
C. E. Badgley, M.D. ....(1955)
University Hospital, Ann Arbor
B. R. Corbus, M.D. ....(1954)
Metz Bldg., Grand Rapids
A. C. Furstenberg, M.D. ....(1954)
Dean, Univ. of Michigan Medical School, Ann Arbor
D. A. Cameron, M.D. ....(1955)
1405 Kales Bldg., Detroit
J. R. Heidenreich, M.D. ....(1953)
Daggett
L. J. Hirschman, M.D. ....(1955)
2619 Munson Avenue, Traverse City
D. H. Kaump, M.D. ....(1953)
Providence Hospital, Detroit
J. M. Robb, M.D. ....(1954)
641 David Whitney Bldg., Detroit
G. H. Scott, Ph.D. ....(1955)
Dean, Wayne Univ. College of Medicine, Detroit
J. M. Sheldon, M.D. ....(1953)
Dept. PG Med., Univ. Hosp., Ann Arbor
E. F. Sladek, M.D. ....(1954)
123 E. Front St., Traverse City
E. D. Spalding, M.D. ....(1953)
10 Peterboro, Detroit 1
F. A. Weiser, M.D. ....(1955)
4162 John R., Detroit

PREVENTIVE MEDICINE COMMITTEE

W. S. Reveno, M.D., *Chairman*....958 Fisher Bldg., Detroit 2
G. E. Anthony, M.D....1015 Detroit Street, Flint
M. R. Burnell, M.D....General Motors Bldg., Detroit
B. E. Brush, M.D....2799 W. Grand Blvd., Detroit 2
A. C. Curtis, M.D....511 First National Bldg., Ann Arbor
H. H. Cummings, M.D....Dept. PG Med., Univ. Hosp., Ann Arbor
S. T. Harris, M.D....220 Pearl, Ypsilanti
A. E. Heustis, M.D....Michigan Dept. Health, Lansing
C. H. Keene, M.D....Kaiser-Frazer Corporation, Willow Run
A. H. Price, M.D....62 W. Kirby, Detroit
J. M. Sheldon, M.D....Dept. PG Med., Univ. Hosp., Ann Arbor
P. E. Sutton, M.D....629 Washington Square Bldg., Royal Oak
J. W. Towey, M.D....Powers
R. W. Waggoner, M.D....University Hospital, Ann Arbor

COMMITTEE ON RHEUMATIC FEVER CONTROL

S. T. Harris, M.D., *Chairman*....220 Pearl Street, Ypsilanti
P. S. Barker, M.D....University Hospital, Ann Arbor
Carleton Dean, M.D....252 Hollister Bldg., Lansing
D. D. Finlayson, M.D....309 Ashmun Street, Sault Ste. Marie
Thomas Francis, Jr., M.D....
School of Public Health, Univ. of Michigan, Ann Arbor
J. H. Fyvie, M.D....Manistique
R. A. Gerisch, M.D....1217 David Whitney Bldg., Detroit
M. S. Hecht, M.D....773 Fisher Bldg., Detroit
F. D. Johnson, M.D....312 Paterson Bldg., Flint
B. I. Johnstone, M.D....555 Fisher Bldg., Detroit
J. D. Littig, M.D....815 Amer. Natl. Bank Bldg., Kalamazoo
E. C. Long, M.D....2626 Rochester, Detroit
L. F. McCoy, M.D....902 Tenth Avenue, Port Huron
R. J. McGillicuddy, M.D....300 W. Ottawa, Lansing
C. J. Poppen, M.D....Michigan Dept. Health, Lansing
L. Paul Ralph, M.D....402 Metz Bldg., Grand Rapids
Mr. Emmet Richards....Alpena
H. H. Riecker, M.D....St. Joseph's Mercy Hospital, Ann Arbor
D. S. Smith, M.D....824 Riker Bldg., Pontiac
Frank Van Schoick, M.D....419 W. High Street, Jackson
L. E. Verity, M.D....Security Bank Bldg., Battle Creek
L. Fernald Foster, M.D., *Secretary*....919 Washington Ave., Bay City
Leon DeVel, M.D., *Medical Co-ordinator*
739 Plymouth Blvd. S.E., Grand Rapids

CANCER CONTROL COMMITTEE

W. A. Hyland, M.D., *Co-Chairman*....Metz Bldg., Grand Rapids
C. H. Keene, M.D., *Co-Chairman*....
Kaiser-Frazer Corporation, Willow Run
F. W. Bald, M.D....610 Mott Foundation Bldg., Flint
M. C. Bennett, M.D....Marquette
D. C. Burns, M.D....314½ Howard Street, Petoskey
L. C. Carpenter, M.D....Metz Bldg., Grand Rapids
E. I. Carr, M.D....300 W. Ottawa, Lansing
R. C. Connelly, M.D....1645 David Whitney Bldg., Detroit
J. N. DeWane, M.D....413 Tenth Avenue, Menominee
A. B. Gwinn, M.D....Hastings
A. E. Heustis, M.D....Mich. Dept. of Health, Lansing
R. C. Hildreth, M.D....458 W. South St., Kalamazoo
L. E. Holly, M.D....878 N. Second Street, Muskegon
A. A. Humphrey, M.D....914 Security Bank Bldg., Battle Creek
B. E. Luck, D.D.S....1512 Olds Tower Bldg., Lansing
A. B. McGraw, M.D....Henry Ford Hospital, Detroit
H. L. Miller, M.D....617 Washington Square Bldg., Royal Oak
H. M. Nelson, M.D....1067 Fisher Bldg., Detroit
R. E. Olsen, M.D....St. Joseph's Mercy Hospital, Pontiac
H. M. Pollard, M.D....University Hospital, Ann Arbor
H. W. Porter, M.D....505 Wildwood, Jackson
F. H. Power, M.D....116 Cass Street, Traverse City
J. M. Wellman, M.D....301 Seymour Avenue, Lansing
N. F. Miller, M.D., *Advisor*....University Hospital, Ann Arbor
F. L. Rector, M.D., *Secretary*....P.O. Box 539, Lansing

MATERNAL HEALTH COMMITTEE

P. E. Sutton, M.D., *Chairman*
629 Washington Square Bldg., Royal Oak
C. M. Bell, M.D....Kendall Prof. Bldg., Grand Rapids
W. G. Birch, M.D....212 Bronson Medical Center, Kalamazoo
G. M. Byington, M.D....1151 Taylor Avenue, Detroit
A. M. Campbell, M.D....
Oakwood Manor, 345 Cherry St. S.E., Grand Rapids
G. B. Corneliuson, M.D....Michigan Dept. of Health, Lansing
A. L. Foley, M.D....Rogers City
Francis Jones, Jr., M.D....716 Olds Tower Bldg., Lansing
H. W. Longyear, M.D....706 Maccabees Bldg., Detroit
S. T. Lowe, M.D....1009 Security Bank Bldg., Battle Creek
H. A. Ott, M.D....706 Maccabees Bldg., Detroit
H. A. Pearse, M.D....852 Fisher Bldg., Detroit 2
L. C. Snademan, M.D....1013 David Whitney Bldg., Detroit 26
D. W. Thorup, M.D....610 Fidelity Bldg., Benton Harbor
Kathryn D. Weburg, M.D....Petoskey
H. R. Williams, M.D....200 N. Ingalls Street, Ann Arbor

VENEREAL DISEASE CONTROL COMMITTEE

A. C. Curtis, M.D., *Chairman*....Univ. Hospital, Ann Arbor
J. A. Cowan, M.D....Michigan Dept. Health, Lansing
Ruth Herrick, M.D....303 Medical Arts Bldg., Grand Rapids
D. K. Hibbs, M.D....622 Post Bldg., Battle Creek
R. H. Holmes, M.D....316 Hackley Union Bldg., Muskegon
H. L. Keim, M.D....1110 David Broderick Tower, Detroit
E. S. Parmenter, M.D....140 E. Washington, Alpena
L. W. Shaffer, M.D....3852 Bishop Road, Detroit
Frank Stiles, M.D....2012 Olds Tower Bldg., Lansing
R. S. Breakey, M.D., *Advisor*....1211 Bank of Lansing Bldg., Lansing

TUBERCULOSIS CONTROL COMMITTEE

J. W. Towey, M.D., *Chairman*....Powers
P. T. Chapman, M.D....1151 Taylor Avenue, Detroit
F. M. Doyle, M.D....1001 American National Bank Bldg., Kalamazoo
J. L. Egle, M.D....Northern Michigan TB San., Gaylord
J. F. Failing, M.D....502 Metz Bldg., Grand Rapids
H. A. Howes, M.D....1515 David Whitney Bldg., Detroit
J. L. Isbister, M.D....Michigan Dept. Health, Lansing
C. E. Lemmon, M.D....1337 David Whitney Bldg., Detroit 26
G. T. McKean, M.D....1515 David Whitney Bldg., Detroit
C. J. Stringer, M.D....Ingham County Sanatorium, Lansing

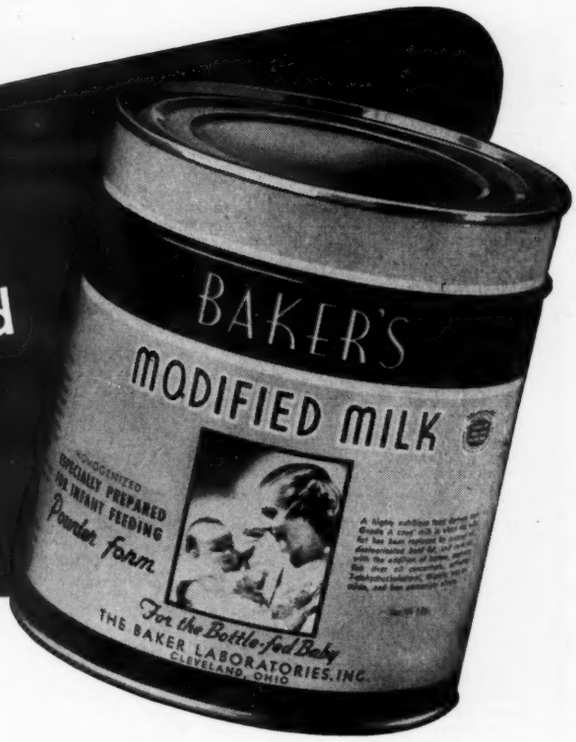
INDUSTRIAL HEALTH COMMITTEE

M. R. Burnell, M.D., *Chairman*....General Motors Bldg., Detroit
W. P. Chester, M.D....5057 Woodward Ave., Detroit 2
E. B. Cudney, M.D....Pontiac Motor Company, Pontiac
W. A. Dawson, M.D....25951 Avondale Road, Inkster
E. A. Irvin, M.D....1343 Buckingham Road, Detroit 30
O. J. Johnson, M.D....207 N. Walnut, Bay City
V. S. Laurin, M.D....804 Hackley Union Bank Bldg., Muskegon
E. F. Lutz, M.D....13-204 General Motors Bldg., Detroit
I. J. Martens, M.D....252 E. Lovell, Kalamazoo
G. P. Moore, M.D....115 S. Mitchell, Cadillac
P. J. Ochsner, M.D....215 Verlinden St., Lansing 15
O. J. Preston, M.D....Chevrolet Motor Company, Flint
D. M. Richmond, M.D....314½ State St., St. Joseph
N. W. Scholle, M.D....1001 Peck Street, Muskegon Heights
M. W. Shellman, M.D....Metz Bldg., Grand Rapids
C. D. Selby, M.D., *Advisor*....1916 Military, Port Huron

(Continued on Page 1376)

POWDER FORM

Recommended for Complemental and Supplemental Infant Feeding



The *powder* form of Baker's Modified Milk is suggested for complemental and supplemental feeding because:

1. The powder form may be safely used for an indefinite time after the can has been opened.

2. Individual feedings may be prepared as needed—without the loss of the remainder of the can's contents.

3. Because of the similarity of its fat chemistry to that of human milk fat and its zero curd tension in the stomach of the infant, Baker's is well-tolerated when used as a complemental or a supplemental feeding.

4. Since Baker's powder and liquid are identical except for their physical form, feedings for the infant whose present formula is Baker's Modified Milk *powder* may be changed later to Baker's *liquid* without subjecting the baby to any changes in fat chemistry, protein, mineral balance, etc.

Because of its fat composition, relatively high protein content and extreme flexibility, Baker's Modified Milk powder is especially well-tolerated by the newborn and is particularly helpful in feeding the premature infant.

Both powder and liquid are prepared from high-quality milk* and contain adequate amounts of all known recommended vitamins (except C) as well as sufficient iron ammonium citrate to supply 7.5 milligrams of iron per quart of normal dilution.

Baker's Modified Milk powder is available in one-pound cans. One pound of powder makes approximately four quarts of formula of normal dilution.

Baker's products are ethically promoted and ethically distributed.

* Made from Grade A milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

MENTAL HYGIENE COMMITTEE

R. W. Waggoner, M.D., *Chairman*....University Hospital, Ann Arbor
I. C. Berlien, M.D.....1753 Guardian Bldg., Detroit
C. W. Bradford, M.D.....419 S. Walnut, Lansing
W. E. Clark, M.D.....Mason
F. P. Currier, M.D.....626 Medical Arts Bldg., Grand Rapids
W. W. Dickerson, M.D.....Caro State Hospital, Caro
J. M. Dorsey, M.D.....65 Moss, Highland Park
G. C. Fink, M.D.....411 N. Ingalls Street, Ann Arbor
T. J. Heldt, M.D.....Henry Ford Hospital, Detroit
L. E. Himler, M.D.....Mercywood Hospital, Ann Arbor
M. H. Hoffmann, M.D.....1311 David Whitney Bldg., Detroit
R. F. Kernkamp, M.D.....1204 David Broderick Tower, Detroit
M. H. Marks, M.D.....8233 W. Chicago Blvd., Detroit 4
F. O. Meister, M.D.....1007 Security Bank Bldg., Battle Creek
H. A. Luce, M.D., *Advisor*.....629 David Whitney Bldg., Detroit

CHILD WELFARE COMMITTEE

G. E. Anthony, M.D., *Chairman*.....1015 Detroit Street, Flint
W. N. Braley, M.D.....12897 Woodward Avenue, Detroit
G. B. Corneliuson, M.D.....Michigan Dept. Health, Lansing
Carleton Dean, M.D.....252 Hollister Bldg., Lansing
M. J. Feeley, M.D.....St. Joseph
J. B. Hassberger, M.D.....316 Wabeek Bldg., Birmingham
Ruth E. Lalime, M.D.....Bear Lake
J. L. Law, M.D.....302 S. State Street, Ann Arbor
O. B. McGillicuddy, M.D.....1816 Olds Tower Bldg., Lansing
Don Marshall, M.D.....252 E. Lovell, Kalamazoo
R. J. Mason, M.D.....308 N. Woodward Avenue, Birmingham
W. S. Nolting, M.D.....15850 E. Warren, Detroit
M. F. Osterlin, M.D.....201 State Bank Bldg., Traverse City
E. T. Palm, M.D.....Crystal Falls
A. L. Richardson, M.D.....651 Fisher Bldg., Detroit
R. S. Simpson, M.D.....1507 Wolverine Tower, Battle Creek
L. P. Sonda, M.D.....544 David Whitney Bldg., Detroit
J. N. P. Struthers, M.D.....Box A, 3501 Willis Road, Ypsilanti
H. A. Towsley, M.D.....University Hospital, Ann Arbor

Sub-Committee on Hearing Defects

O. B. McGillicuddy, M.D., *Chairman*
1816 Olds Tower Bldg., Lansing
R. H. Criswell, M.D.....407 Phoenix Bldg., Bay City
R. G. Ferris, M.D.....205 Hanna Bldg., Birmingham
M. H. Pike, M.D.....209 Reinhart Bldg., Midland

Sub-Committee of Ophthalmologists

Don Marshall, M.D., *Chairman*.....252 E. Lovell, Kalamazoo
J. R. Doty, M.D.....Lapeer
A. D. Ruedemann, M.D.....1633 David Whitney Bldg., Detroit

IODIZED SALT COMMITTEE

B. E. Brush, M.D., *Chairman*.....2799 W. Grand Blvd., Detroit 2
H. A. Towsley, M.D., *Vice Chairman*.....
University Hospital, Ann Arbor
J. B. Blodgett, M.D.....606 Kales Bldg., Detroit 26
R. B. Burrell, M.D.....907 American National Bank, Kalamazoo
F. E. Dodds, M.D.....1336 Lewis Street, Flint
C. F. Lemley, M.D.....533 Fisher Bldg., Detroit
R. C. Moehlig, M.D.....964 Fisher Bldg., Detroit 2
D. G. Pike, M.D.....876 E. Front St., Traverse City
R. L. Waggoner, M.D.....St. Louis

GERIATRICS COMMITTEE

A. H. Price, M.D., *Chairman*.....62 W. Kirby, Detroit
F. A. Weiser, M.D., *Vice Chairman*.....4162 John R., Detroit
W. M. LeFevre, M.D., *2nd Vice Chairman*.....
289 W. Western Avenue, Muskegon
R. M. Athay, M.D.....Wayne County General Hospital, Eloise
F. W. Baske, M.D.....923 Maxine St., Flint
J. R. Brink, M.D.....308 Metz Bldg., Grand Rapids
E. F. Crippen, M.D.....Mancelona
R. E. Dustin, M.D.....Tecumseh
P. C. Gittins, M.D.....732 Maccabees Bldg., Detroit
J. J. Lightbody, M.D.....501 David Whitney Bldg., Detroit
Mark Marshall, M.D.....St. Joseph's Mercy Hospital, Ann Arbor
E. S. Rhind, M.D.....300 Court Street, Sault Ste. Marie
H. H. Riecker, M.D.....St. Joseph's Mercy Hospital, Ann Arbor
D. R. Smith, M.D.....Iron Mountain
F. C. Swartz, M.D.....215 N. Walnut Street, Lansing
G. C. Thosteson, M.D.....1139 David Whitney Bldg., Detroit 26
S. C. Wiersma, M.D.....Hackley Union Bank Bldg., Muskegon
H. W. Woughter, M.D.....1312 Mott Foundation Bldg., Flint

Sub-Committee to Study Problems of Caring for Aged

F. A. Weiser, M.D., *Chairman*.....4162 John R., Detroit
Mark Marshall, M.D.....St. Joseph's Mercy Hospital, Ann Arbor
H. H. Riecker, M.D.....St. Joseph's Mercy Hospital, Ann Arbor
D. R. Smith, M.D.....Iron Mountain

Sub-Committee on Diabetes Control

W. M. LeFevre, M.D., *Chairman*
289 W. Western Avenue, Muskegon
F. W. Baske, M.D.....923 Maxine Street, Flint
J. R. Brink, M.D.....308 Metz Bldg., Grand Rapids
G. C. Thosteson, M.D.....1139 David Whitney Bldg., Detroit
S. C. Wiersma, M.D.....Hackley Union Bank Bldg., Muskegon

SCIENTIFIC RADIO COMMITTEE

J. M. Sheldon, M.D., *Chairman*.....University Hospital, Ann Arbor
C. B. Beeman, M.D.....509 Kendall Prof. Bldg., Grand Rapids
F. J. Kemp, M.D.....1115 Peoples State Bank Bldg., Pontiac
C. E. Lemen, M.D.....216 E. Front Street, Traverse City
K. L. Swift, M.D.....869 Fisher Bldg., Detroit
K. W. Toothaker, M.D.....320 Townsend Street, Lansing
E. C. Vonder Heide, M.D.....17190 Strathmore, Detroit

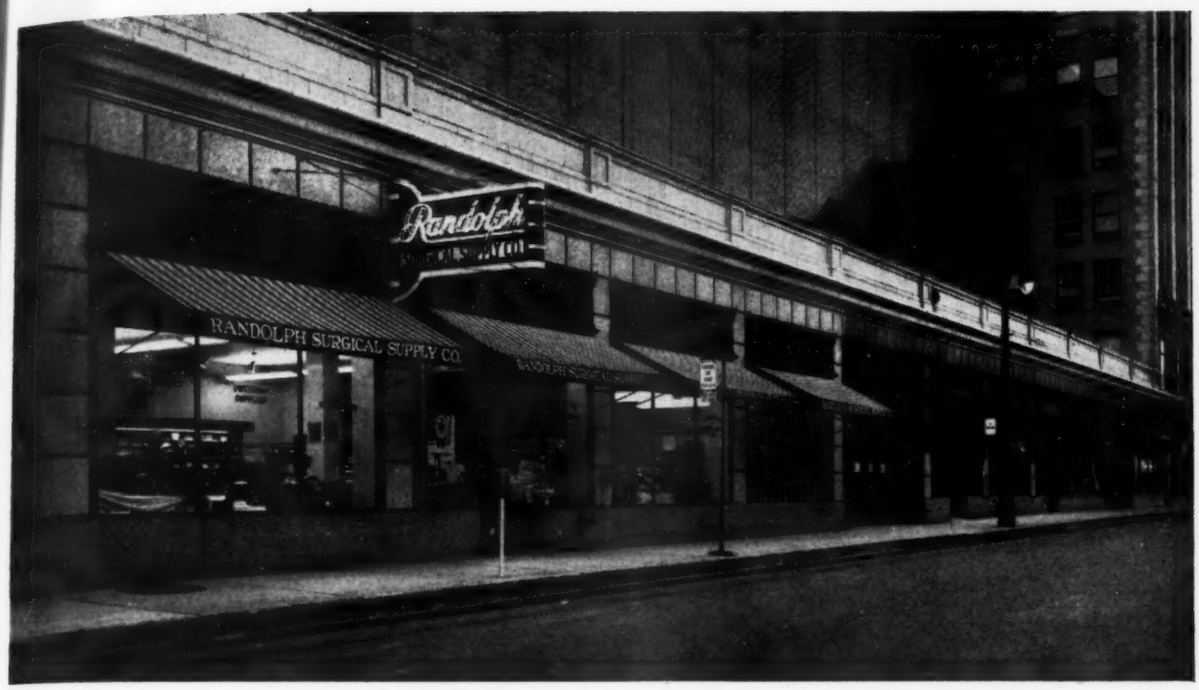
PUBLIC RELATIONS COMMITTEE

C. A. Payne, M.D., *Chairman*
Blodgett Memorial Hospital, Grand Rapids
R. A. Johnson, M.D., *Vice Chairman*.....7815 E. Jefferson, Detroit
R. W. Teed, M.D., *Vice Chairman*....215 S. Main Street, Ann Arbor
S. E. Andrews, M.D.....224 E. Cedar St., Kalamazoo
H. G. Bacon, Jr., M.D.....Scottville
F. A. Barbour, M.D.....1439 Mott Fdtn. Bldg., Flint
J. F. Beer, M.D.....104 N. Riverside Drive, St. Clair
F. L. Doran, M.D.....Metz Bldg., Grand Rapids
G. A. Drake, M.D.....Petoskey
H. D. Dykhuizen, M.D.....710 Hackley Union Bank Bldg., Muskegon
H. B. Fenech, M.D.....324 Professional Bldg., Detroit
William Fiedling, M.D.....Norway
S. A. Fiegel, M.D.....Sturgis
D. L. Finch, M.D.....806 Security National Bank Bldg., Battle Creek
R. A. Frary, M.D.....423 E. Elm Avenue, Monroe
H. A. Furlong, M.D.....932 Riker Bldg., Pontiac
W. G. Gamble, Jr., M.D.....2010 Fifth Avenue, Bay City
Samuel Glassman, M.D.....60 W. Hancock, Detroit
L. E. Grate, M.D.....304 Mason Street, Charlevoix
A. B. Gwinn, M.D.....City Bank Bldg., Hastings
S. W. Hartwell, M.D.....452 W. Western Avenue, Muskegon
L. T. Henderson, M.D.....13038 E. Jefferson, Detroit
W. J. Herrington, M.D.....Bad Axe
N. J. Hershey, M.D.....107 N. 2nd Street, Niles
H. C. Hill, M.D.....Howell
A. B. Hodgman, M.D.....612 Douglas, Kalamazoo
F. P. Husted, M.D.....812 N. Grant, Bay City
K. H. Johnson, M.D.....1116 Olds Tower Bldg., Lansing
R. C. Kingswood, M.D.....90 E. Warren, Detroit
R. S. Libke, M.D.....Gaylord
E. C. Long, M.D.....2626 Rochester, Detroit
O. B. McGillicuddy, M.D.....1816 Olds Tower Bldg., Lansing
H. J. Meier, M.D.....87 W. Pearl Street, Coldwater
G. E. Millard, M.D.....2900 W. Grand Blvd., Detroit
B. T. Montgomery, M.D.....309 Ashmun Street, Sault Ste. Marie
P. T. Mulligan, M.D.....91 Cass Avenue, Mt. Clemens
E. S. Oldham, M.D.....Breckenridge
A. C. Pfeifer, M.D.....Mt. Morris
L. A. Pratt, M.D.....3919 John R, Detroit
W. Z. Rundles, M.D.....304 First National Bldg., Flint
A. E. Schiller, M.D.....2008 David Broderick Tower, Detroit
E. F. Sladek, M.D.....123 E. Front Street, Traverse City
E. L. Spoehr, M.D.....22832 Woodward Avenue, Ferndale
C. K. Stroup, M.D.....2002 Court Street, Flint 3
R. W. Waggoner, M.D.....University Hospital, Ann Arbor
C. L. Weston, M.D.....1306 N. Washington Street, Owosso
Wayne L. Whitaker, Ph.D.....University of Michigan, Ann Arbor
A. H. Whittaker, M.D.....1427 E. Jefferson, Detroit 7
J. T. P. Wickliffe, M.D.....1167 Calumet Avenue, Calumet
V. M. Zerbi, M.D.....315 N. Adams Street, Ypsilanti
L. Fernald Foster, M.D., *Advisor*.....919 Washington Ave., Bay City
L. W. Hull, M.D., *Advisor*.....1701 David Whitney Bldg., Detroit

Committee on Newspapers

C. L. Weston, M.D., *Chairman*.....1306 N. Washington St., Owosso
A. B. Gwinn, M.D.....City Bank Bldg., Hastings
R. A. Johnson, M.D.....7815 E. Jefferson, Detroit
R. C. Kingswood, M.D.....90 E. Warren, Detroit

(Continued on Page 1378)



For all your everyday needs RANDOLPH is adequately equipped and welcomes requests for special items not commonly manufactured.

VISIT THE COMPLETE RANDOLPH SHOWROOMS TODAY

- **OFFICE FURNITURE**
- **MEDICAL EQUIPMENT**
- **SURGICAL INSTRUMENTS**
- **HOSPITAL EQUIPMENT & SUPPLIES**
- **PHARMACEUTICALS**

"For Finer Equipment"

Randolph Surgical

SUPPLY COMPANY

PHYSICIANS AND HOSPITAL SUPPLIES

60 COLUMBIA ST. WEST • WOODWARD 1-4180 • FOX THEATRE BLDG. • DETROIT 1, MICH.

Committee on Television

A. E. Schiller, M.D., *Chairman*
2008 David Broderick Tower, Detroit
R. A. Frary, M.D.....423 E. Elm Avenue, Monroe
E. C. Long, M.D.....2626 Rochester, Detroit
R. W. Teed, M.D.....215 S. Main Street, Ann Arbor

Committee on Speakers Bureau

S. E. Andrews, M.D., *Chairman*.....224 E. Cedar Street, Kalamazoo
L. T. Henderson, M.D.....13038 E. Jefferson, Detroit
N. J. Hershey, M.D.....107 N. 2nd Street, Niles
F. P. Husted, M.D.....812 N. Grant, Bay City

Committee on Cinema

E. F. Sladek, M.D., *Chairman*.....123 E. Front St., Traverse City
P. T. Mulligan, M.D.....91 Cass Avenue, Mt. Clemens
Wayne L. Whitaker, Ph.D.....University of Michigan, Ann Arbor

Committee on Public Relations Publications

L. A. Pratt, M.D., *Chairman*.....3919 John R, Detroit
William Fiedling, M.D.....Norway
H. A. Furlong, M.D.....932 Riker Bldg., Pontiac

Committee on Education Programs in Schools and Universities

H. J. Meier, M.D., *Chairman*.....87 W. Pearl Street, Coldwater
K. H. Johnson, M.D.....1116 Olds Tower Bldg., Lansing
O. B. McGillicuddy, M.D.....1816 Olds Tower Bldg., Lansing
R. W. Waggoner, M.D.....University Hospital, Ann Arbor
A. H. Whittaker, M.D.....1427 E. Jefferson Avenue, Detroit

ETHICS COMMITTEE

H. B. Barker, M.D., *Chairman* (1955)...1006 Riker Bldg., Pontiac
W. L. Harrigan, M.D.....(1953).....Mt. Pleasant
H. L. Morris, M.D.....(1955).....1069 Fisher Bldg., Detroit
E. A. Oakes, M.D.....(1956).....401 River St., Manistee
H. W. Porter, M.D.....(1954).505 Wildwood Ave., Jackson
A. H. Price, M.D.....(1954).....62 W. Kirby, Detroit
W. F. Strong, M.D.....(1956).....Ontonagon
M. R. Weed, M.D.....(1953).1997 E. Grand Blvd., Detroit

LEGISLATIVE COMMITTEE

L. A. Drolett, M.D., *Chairman*.....903 Prudden Bldg., Lansing
O. B. McGillicuddy M.D., *Vice Chairman*
1816 Olds Tower Bldg., Lansing
William Bromme, M.D.....318 Professional Bldg., Detroit
G. V. Conover, M.D.....420 Genesee Bank Bldg., Flint
J. C. Elliott, M.D.....Buchanan
L. W. Hull, M.D.....1701 David Whitney Bldg., Detroit
J. R. Pedden, M.D.....445 Cherry St. S.E., Grand Rapids
J. S. Rozan, M.D.....511 Bank of Lansing Bldg., Lansing
LeMoyne Snyder, M.D.....705 American State Bank Bldg., Lansing
R. V. Walker, M.D.....1255 David Whitney Bldg., Detroit

MEDIATION COMMITTEE

W. Z. Rundles, M.D., *Chairman*.....304 First National Bldg., Flint
G. A. Drake, M.D.....Petoskey
A. E. Gamon, II, M.D.....514 First Savings & Loan Bldg., Saginaw
E. T. Morden, M.D.....109 E. Maumee, Adrian
R. W. Teed, M.D.....215 S. Main Street, Ann Arbor
Charles Ten Houten, M.D.....Paw Paw
E. H. Terwilliger, M.D.....South Haven
Ralph Wadley, M.D.....333 Seymour, Lansing

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

I. C. Berlien, M.D., *Chairman*....1753 Union Guardian Bldg., Detroit
A. B. Aldrich, M.D.....Houghton
W. W. Babcock, M.D.....868 Fisher Bldg., Detroit
W. J. Butler, M.D.....12 Peoples State Bank Bldg., St. Joseph
W. S. Stinson, M.D.....101 W. John Street, Bay City

ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

H. H. Heuser, M.D., *Chairman*.....207 Davidson Bldg., Bay City
H. M. Bishop, M.D.....515 S. Jefferson, Saginaw
R. W. Emerick, M.D.....878 N. Second St., Muskegon
E. A. Osius, M.D.....901 David Whitney Bldg., Detroit
R. W. Pomeroy, M.D.....609 N. Washington, Lansing
Otto van der Velde, M.D.....33 W. 8th Street, Holland
Ralph W. Shook, M.D., *Advisor*
611 American Natl. Bank Bldg., Kalamazoo

ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

M. F. Osterlin, M.D., *Chairman*
201 State Bank Bldg., Traverse City
E. R. Elzinga, M.D.....315 N. Front Street, Marquette
H. W. Harris, M.D.....301 Seymour Avenue, Lansing
B. B. King, M.D.....210 Fidelity Bldg., Benton Harbor
E. E. Martmer, M.D.....526 Professional Bldg., Detroit
N. R. Moore, M.D.....704 N. Jackson, Bay City
F. H. Purcell, M.D.....1808 David Broderick Tower, Detroit
H. W. Riggs, M.D.....St. Joseph's Mercy Hospital, Ann Arbor
H. H. Stryker, M.D.....Borgess Hospital, Kalamazoo
F. P. Walsh, M.D.....474 Fisher Bldg., Detroit
J. E. Webber, M.D.....310 E. Fulton St., Grand Rapids

You and Your Business

HIGHLIGHTS OF SEPTEMBER SESSION OF THE COUNCIL,

September 21 and 26, 1952

Three meetings of The Council were held during the 87th Annual Session of the Michigan State Medical Society in Detroit. One hundred four items were presented and discussed by the twenty-five members (eighteen Councilors, the Speaker and the Vice Speaker of the House of Delegates, the President, President-Elect, Immediate Past President, Secretary and Treasurer). A total of 219 cumulative hours was contributed by these members of The Council to weigh and decide upon the problems facing the entire medical profession of Michigan.

The Council, Michigan State Medical Society, 1952-53

Front row *(left to right):* W. D. Barrett, M.D., Detroit; R. H. Baker, M.D., Pontiac; R. J. Hubbell, M.D., Kalamazoo; Chairman William Bromme, M.D., Detroit; L. W. Hull, M.D., Detroit; W. S. Jones, M.D., Menominee; L. Fernald Foster, M.D., Bay City.

Standing (left to right): J. D. Miller, M.D., Grand Rapids; Wilfrid Haughey, M.D., Battle Creek; G. B. Saltonstall, M.D., Charlevoix; D. B. Wiley, M.D., Utica; R. S. Breakey, M.D., Lansing; C. A. Paukstis, M.D., Ludington; Ralph W. Shook, M.D., Kalamazoo; J. E. Livesay, M.D., Flint; H. H. Hiscock, M.D., Flint; F. H. Drummond, M.D., Kawkawlin; A. H. Miller, M.D., Gladstone; Arch Walls, M.D., Detroit; H. B. Zemmer, M.D., Lapeer; G. W. Slagle, M.D., Battle Creek; W. B. Harm, M.D., Detroit; L. C. Harvie, M.D., Saginaw; B. M. Harris, M.D., Ypsilanti.

Absent on MSMS business: Otto O. Beck, M.D., Birmingham, and Wm. A. Hyland, M.D., Grand Rapids.

• **Reorganization of The Council: William Bromme, M.D., Detroit, was re-elected chairman; H. B. Zemmer, M.D., Lapeer, was chosen as vice chairman; W. S. Jones, M.D., of Menominee, was again made head of the Finance Committee; D. Bruce Wiley, M.D., Utica, was re-elected chairman of the County Societies Committee; and C. A. Paukstis, M.D., of Ludington, was given the post of chairman of the Publication Committee.**

• **The monthly financial reports** were studied and approved. **Bills payable** were reviewed **and ordered paid.**

• **The following Committee reports were considered:** (a) **Finance Committee,** meeting of September 20; (b) **Rheumatic Fever Control Committee,** September 10; (c) **Medical Advisory Committee to Michigan Hospital Service,** meeting of August 21.

Co-ordinating Committee re President's Commission on Health Needs of the Nation, meetings of August 27 and September 10.

A special vote of thanks was extended to **C. E. Umphrey, M.D.,** chairman of this committee, for his splendid work in co-ordinating the efforts of all health, hospital and medical agencies in con-

(Continued on Page 1382)

In early Rheumatoid arthritis

to increase and accelerate the appearance of remissions

"Gold salts, if administered during the first year of rheumatoid arthritis, increase and accelerate the appearance of remissions."* A remission rate of 66 per cent was recently noted in a group of gold-treated patients with rheumatoid arthritis of 12 months or less duration. Similar patients treated without gold showed a remission rate of only 24.1 per cent. On the average, remissions appeared 10 months sooner in the gold-treated cases.

SOLGANAL®
(aurothioglucose)

*Adams, C. H., and Cecil, R. L.: Ann. Int. Med. *33*:163, 1950.

Schering CORPORATION • BLOOMFIELD, N. J.

SOLGANAL

SCHERING

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1380)

nection with the September 23 Detroit Hearing.

A letter of congratulation and commendation also was authorized to be sent to Co-Chairman **K. B. Babcock, M.D.,** Detroit, for making it possible for individuals who have a basic understanding of the health, hospital and medical needs of the people of this area to be heard at the September 23 Detroit hearing.

• **Beaumont Breakfast of September 25.** The Council felt that the responsibility for the Beaumont Memorial was now on the local level, to be stimulated by members of the MSMS Council. The chairman of The Council was authorized to contact each member of The Council to urge him to visit every component county society in his district and see if he can obtain 100 per cent (or as near 100 per cent as possible) in contributions to the Beaumont Memorial—and to report his work and success to The Council at its Annual Session of January 30-31, 1953.

President Beck reported that contributions, to September 20, 1952, amounted to $21,190, and that approximately $2,000 had been added by MSMS members who attended the Annual Session in Detroit. The Council expressed sincere thanks to all M.D.'s who have been generous in their contributions to the Beaumont Memorial.

Prison Report.—President Beck offered to The Council a report on the 1951 survey of the hospital and medical facilities of the State Prison of Southern Michigan at Jackson. This re-survey—the first being made four years ago—indicated a great improvement in health facilities at the Jackson Prison—but the Committee recommended additional betterments and advancement in the service. President Beck called the report "one of the finest accomplishments of the Michigan State Medical Society."

• A letter of congratulations and thanks to **R. L. Finch, M.D.** (Chief Physician of the State Prison of Southern Michigan) was authorized.

• **A. D. Allen, M.D.,** of Bay City, and **John R. Rodger, M.D.,** of Bellaire, were recommended to the Governor to succeed themselves as members of the Hospital Advisory Council (Hill-Burton Act) as MSMS representatives.

• **A Special Committee to study the need for a revision of the Model Constitution and By-Laws for County Medical Societies was authorized.** The present model is dated 1937.

• **Goldie B. Corneliuson, M.D., was reappointed** to serve as an MSMS representative to the **Committee for Improvement of Nursing Services,** a committee of the Michigan Nursing Center Association.

• **At the MSMS booth at the State Fair** (September 2-5, 1952), 77,520 pieces of literature were distributed and 217 showings of medical films were made. Thanks were extended to the 10 members of the Woman's Auxiliary and to representatives of the Michigan Health Council who covered the booth in behalf of the State Society.

• **A report on Housing the Aging,** meeting in Ann Arbor on July 24-26, as drafted by A. Hazen Price, M.D., Detroit, was accepted with a vote of thanks.

• **The Special Committee to study a health and accident insurance program for MSMS members** reported on a meeting with representatives of insurance brokers from Chicago. The Committee felt that the proffered contract did not meet the needs of the doctors of Michigan and could not be accepted. The Council instructed that such a report be given to the House of Delegates. Subsequently, the House of Delegates instructed that the Committee, enlarged to five, continue its study. The current committee is composed of: W. S. Jones, M.D., Menominee, Chairman; L. Fernald Foster, M.D., Bay City; J. Duane Miller, M.D., Grand Rapids; Arch Walls, M.D., Detroit; and Mr. J. Joseph Herbert, Manistique, MSMS Legal Counsel.

• **The monthly report of the Public Relations Counsel** included: (a) **9 television shows, 6 radio shows and 3 service club talks** have been arranged during the 1952 MSMS Annual Session in Detroit, including the WWJ dramatic radio show on "The Strange Case of Dr. Beaumont." All time used over the air was contributed by the Detroit radio and television stations at no cost to the Michigan State Medical Society; (b) **the revision of the Medical Associates brochure** has resulted in a great demand for same in Michigan and throughout other states; (c) **the Good Citizenship Campaign** is continuing with success: it is expected that the highest percentage ever achieved in the medical profession will be registered at the voting booths on November 4, 1952.

(Continued on Page 1384)

MICHIGAN INDUSTRIAL HEALTH PROGRAM TO BE PRESENTED IN MARCH

The fourth annual Michigan Industrial Health Day will be held Tuesday, March 10, 1953, at the Sheraton-Cadillac Hotel, Detroit—the date preceding the 1953 Michigan Clinical Institute. A full program of scientific papers beamed to industrial medicine and surgery will feature the day.

E. A. IRVIN, M.D.

A reception and testimonial banquet in honor of E. A. Irvin, M.D., Detroit, President of the national Industrial Medical Association, will follow at the Sheraton-Cadillac Hotel.

The complete program will be published as a special feature of the December Number of THE JOURNAL.

All members of the Michigan State Medical Society are cordially invited to attend the Michigan Industrial Health Day and the banquet of March 10, 1953, in Detroit.

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1382)

• **Three nominees for the Michigan Foremost Family Physician Award** were selected for presentation to the House of Delegates on September 22: S. L. Loupee, M.D., Dowagiac; D. J. McColl, M.D., Port Huron, and E. L. Thirlby, M.D., Traverse City.

• **The Supplemental Report of The Council,** for submission to the House of Delegates on September 22, was developed and the thirteen items were approved.

• **Matters referred to The Council by the 1952 MSMS House of Delegates** were discussed and action taken on several; the balance was referred to the meeting of October 23, pending receipt of transcript of the House of Delegates Proceedings.

• **B. M. Harris, M.D., was chosen as chairman of the Study Committee on Inclusion of Assistant's Fees** in Blue Shield, in insurance companies, and in Uniform Fee Schedule for Governmental Agencies—with power to nominate the members of his Committee.

• **Appointment of members to the 1952-53 MSMS Committees** was announced by President R. J. Hubbell, M.D., Kalamazoo.

• **Two matters of mutual interest** were discussed with State Health Commissioner A. E. Heustis, M.D., Lansing.

• **A vote of official thanks to all who helped make the 1952 Annual Session an outstanding success** (registration of 3,605, an all-time record, despite conflicts with the American College of Surgeons and the American Roentgen Ray conventions) was placed on the minutes of The Council.

• **A vote of thanks was extended to Wyeth, Inc., of Philadelphia** and to its officers Stuart V. Smith, D. J. Withington and R. G. Wilder, for presentation to the Michigan State Medical Society of the Dean Cornwell painting "Beaumont and St. Martin" on September 23 in Detroit. This famous and valuable painting is to be housed in the MSMS home in Lansing until July, 1954, when it is to be moved to the completed Beaumont Memorial on Mackinac Island.

• **A vote of thanks was extended to the State Journal Advertising Bureau** and its Director A. J. Jackson for their printed recognition of the Journal of the Michigan State Medical Society as a model of good publishing.

• **Request was granted to house the archives of the Woman's Auxiliary** to the Michigan State Medical Society at 606 Townsend, Lansing.

• **A resolution from the Michigan Pathological Society** offering all co-operation in the passage of a medical examiners system bill through the Michigan Legislature was read. C. Allen Payne, M.D., of Grand Rapids, was selected as MSMS representative to attend an October 13 meeting in Chicago of the College of American Pathologists to discuss the medical examiner system bill and other important and related matters of law and forensic medicine.

PROBLEM OF THE AGING

The Research Council for Economic Security, in its July report, asks and answers the question: Why should not retirement be handled selectively? Clarence B. Randall, in his book A Creed for Free Enterprise, makes this statement:

"Since all men are different, and individual characteristics vary widely in later years, why should not retirement be handled selectively, keeping those who are up in their prime and releasing only those as to whom

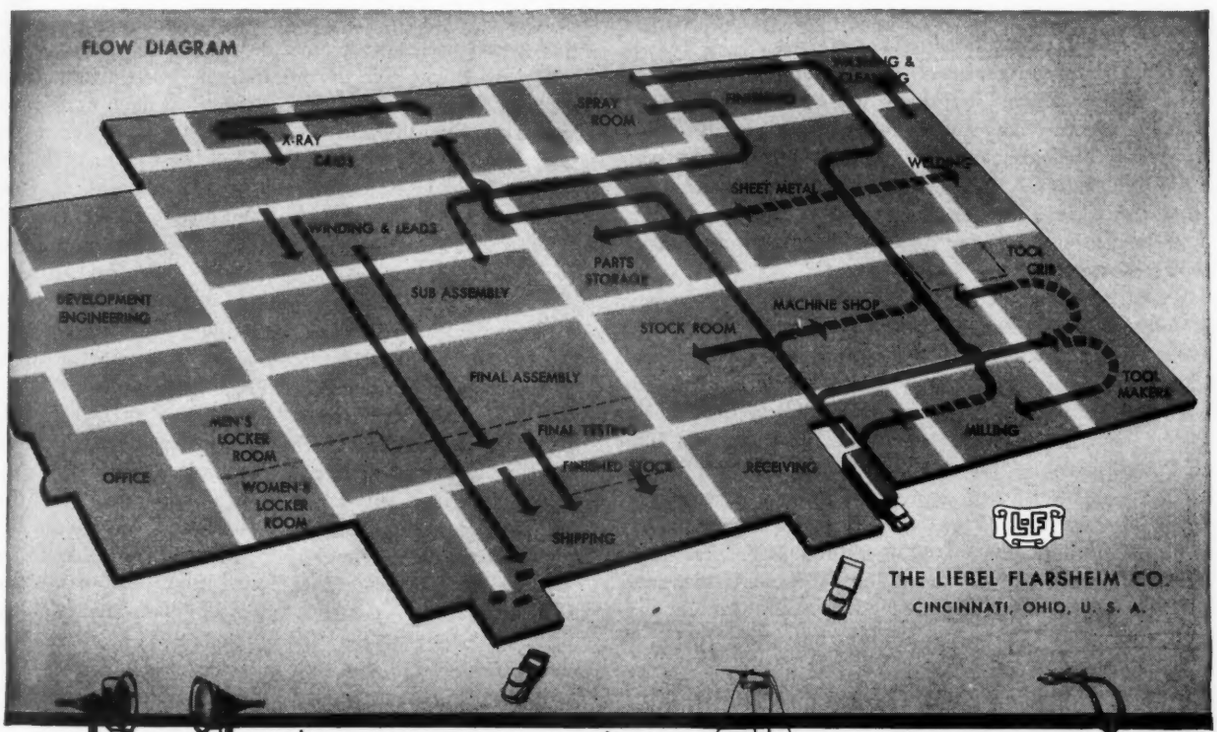
(Continued on Page 1388)

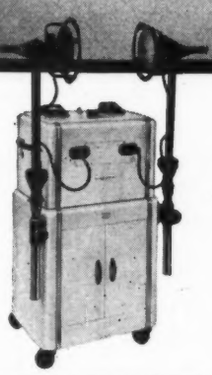
It's a Big Plant. Situated on an 11½ acre site with floor area sufficient for nearly 1000 average hospital rooms, this modern one floor manufacturing operation greatly extends the range of L-F service to the medical profession.

It's a Modern Plant. Basic materials are received, handled and processed in their flow through the factory, by every applicable modern technique. The development, manufacturing and testing facilities are the finest and most up-to-date in this industry. From turning and stamping to finishing and polishing every manufacturing step is quality-controlled. Such modern facilities and exacting care ensures the extra value which distinguishes the Liebel-Flarsheim name.

It's a Plant for the Future—Yours and Ours! We share our pride in our new home with the M.D.'s of America, whose patronage and loyalty have made it possible. We aim to justify your confidence by maintaining our long-established reputation for dependable and trustworthy electromedical products.

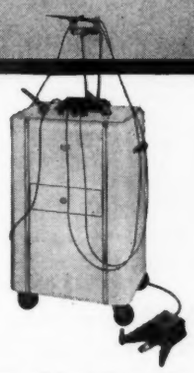
Streamlined flow in manufacturing ensures maximum quality and dependability for BOVIES, BUCKYS and other L-F apparatus.



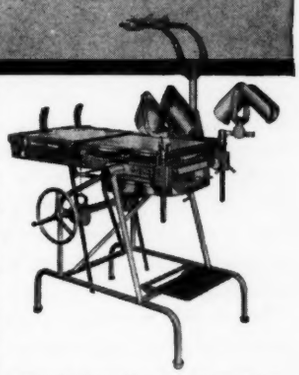


SHORT WAVE DIATHERMY

POTTER BUCKY DIAPHRAGM



"0-3" OFFICE BOVIE



UROLOGICAL X-RAY TABLE

PROBLEM OF THE AGING

(Continued from Page 1384)

there is doubt? This is a plausible suggestion, often urged by those who have a particular man in mind who looks for all the world as good at sixty-five as he did at fifty. There are many such. . . . Among junior executives at about the age of forty there is never any doubt but that there should be compulsory and complete retirement for older men at not later than the age of sixty-five. The doubts come to those who have passed sixty, and the subtle self-hypnosis of indispensability seems to be associated with thinning hair, bifocals, dentures, and longer belts. It is the occupational disease of seniors."

Randall concludes, "I am convinced that for purposes of sound administration there must be a fixed age limit with compulsory retirement from active day-to-day responsibility, as distinguished from wisdom duties such as membership on a board of directors." Preferential retirement, whereby one executive is retained upon reaching a certain age while another is retired, is poor personnel practice. Randall feels that it can only give rise to suspicions of favoritism, and result in lowered company morale. He notes also that while medical science may some day outdate the sixty-five-year limit, this time has not yet arrived.

* * *

Public and private funds for housing aged persons are being considered in Detroit, Boston, Los Angeles, and New York. New York already reserves 5 per cent of all state-aided public housing for the aged. In Florida, the State University as well as the state administration have been studying for three years the possibility of erecting entire villages for retired persons and their families. The Massachusetts legislature is considering a $5 million fund to build 400 to 500 special housing units. All the plans envisage special kitchens, recreation, and other facilities to serve the specific needs of elderly persons.

Recently enacted increases in social security benefits provide: (1) increases of $5 a month or 12½ per cent, whichever is greater, in old age and survivor insurance benefits representing an average increase of $60 per month; (2) commensurate increases in Railroad Retirement System benefits; (3) an increase in the maximum limit of outside earnings for annuitants from $50 per month to $75; (4) an OASI monthly employment credit of $160 for members of the armed forces during 1947-1953; (5) an increase of $250 million in federal funds for grants to the states for public assistance which permits an increase in benefits of $3 a month for dependent children and $5 a month for the aged, the blind, and the disabled.

Nearly three out of every five males aged sixty-five to sixty-nine are still in the labor force, reports the Statistical Bureau of the Metropolitan Life Insurance Company. Of all older males, aged seventy to seventy-four, two out of every five are employed or seeking employment. Occupation seems to have something to do with the aged remaining in the labor force. Thus, older men tend to remain at work longer in agricultural, managerial, and self-employed positions than those in hazardous jobs.

Economic security, pre-retirement preparation, and post-retirement adjustment are the three legs of the security stool, say Lawrence J. Ackerman and Walter C. McKain, Jr., in "Retirement Programs for Industrial Workers," *Harvard Business Review* (July-August, 1952). Basing their observations of the current scene on their poll of 403 companies, they acknowledge rapid advances in retirement programs, but point to many uncharted fields.

Of the firms polled, 15 per cent had no pensions, no pre-retirement health or education programs, and no post-retirement contracts. Nearly one-quarter of the companies had nothing more than a pension plan. The authors note, however, that many existing plans and programs are being revised. Overall, Ackerman and McKain feel that "industry, aided by government and the community, each in its respective sphere, is in the progress of formulating a highly humane and civilized approach to the older person in industry."—*Insurance Economics Survey.*

State Commissions on Aging Decide to Continue Under FSA Guidance.—For a time at least, the federal government will continue to furnish central guidance for states attempting to set up medical and other programs for the aged. Decision to remain under the wing of Federal Security Agency's Committee on Aging and Geriatrics (Clark Tibbitts, director) was reached at the conclusion of a three-day conference of state commissions on aging and federal officials. The question was whether to set up an interim national organization with no ties to the federal government. During discussion, it was argued that a new non-federal association wouldn't be practical because as yet so few states (14) have commissions on aging, and the responsibilities and authority of many of these are uncertain.

John L. Thurston, deputy administrator of Federal Security Agency, told the delegates that they were welcome to return to Washington and the FSA with their problems. He said he thought it was fitting for the federal government to serve as a catalyst or stimulator in such a new and expanding area.

Conference work groups brought out that the public generally is unaware of the growng problem of caring for the aged and that agencies and facilities for them are lacking in many areas. There was agreement that the problems can best be handled at the state and community level. Panel speakers also emphasized that (a) the trend is toward committees authorized by state legislatures, with citizen's advisory committees or lay members participating, (b) subcommittees of commissions generally fall into four groups: employment, health, personal adjustment and housing-living arrangements, and (c) major function of commissions is formulation of plans for action programs.—AMA *Capitol Clinic.*

* * *

A hygiene of aging program is being established in the public health service of the Federal Security Agency. The purpose of the program, according to Surgeon General Leonard A. Scheele, is to advise health departments on the development of these activities. It is also designed to help health departments consider the needs and problems of the aging group in all their programs.

(Continued on Page 1390)

PROBLEM OF THE AGING

(Continued from Page 1388)

"More health services will be needed for older persons," Dr. Scheele said. "Increased emphasis will have to be placed on preventing and alleviating the ills of older adults and on helping them play a more active role in the community." The hygiene of aging program will be operated by the Division of Chronic Disease and Tuberculosis of the Bureau of State Services.

UTILIZATION OF PREPAID MEDICAL PLANS

The Heller Committee in California recently published the results of a study of the utilization of medical care plans. The study covered 455 families residing in the San Francisco Bay region. The family incomes ranged from $1,553 to $21,690 per year, with the mean $4,147, the median income, $3,823. In 60 per cent of the families some member was covered by some form of medical prepaid insurance for some period during 1947-1948. Less than 20 per cent had all members of the family covered. Less than half of the 1,504 individuals making up these families were covered by any plan during any part of the year. Two-thirds were covered by hospital insurance only. About one fourth of those members of the plans who received some type of medical care received care through a prepaid plan. Ninety per cent of the patients who received care through a plan paid some additional costs. (In California some of the plans specify additional costs for certain services.) In most cases this additional charge was less than $25.

MEMBERSHIP IN HEALTH PLANS

A survey by the Health Insurance Council of memberships as of 1951 found that 85.9 million persons were protected against hospital expense, 65.4 million had surgical expense coverage, 27.7 million had medical expense protection, and 39.7 million had protection against loss of income resulting from disability. This does not include persons covered under state disability compensation plans. The organizations covered by this survey included insurance companies, Blue Cross, Blue Shield, local medical societies, and other independent plans adopted by industry, employe benefit associations, and private clinics.

HOSPITAL OPERATING COSTS

The cost of operating a hospital has been rising at the rate of one per cent a month for the last ten years. Ellis Walker, in *Hospital Management* (June, 1952) quotes Harry Becker, associate director of the Commission on Financing of Hospital Care, as saying, "This cost may be as much as 20 per cent higher in 1954 and 1955 than it is today." In a panel discussion at the Annual Convention of Western Hospitals, where this statement was made, one of the recommendations called for an expansion of prepaid plans to cover diagnostic services in advance of actual hospitalization. This would tend to cut costs since periodic check-ups would catch many illnesses in their early stages before hospitalization became necessary. The panel is reported also to have stated that "one of the chief faults of present insurance plans is their failure to cushion the financial blow of a long-term illness."

VETERANS AFFAIRS

The American Legion's Medical Advisory Board, fearful that economies are pulling the Veterans Administration's medical program from the "high plateau" of recent years, is appealing to U. S. Budget Bureau and Congress. Following a meeting of the board, Chairman Leonard G. Rowntree said the members hoped that the Budget Bureau would come up with a "realistic" budget for fiscal 1954. The bureau is now working on that budget. In addition, Dr. Rowntree said the board was counting on the next Congress passing a deficiency appropriation to restore VA beds eliminated by budget cuts voted by the last Congress. The best that could be expected, he said, would be funds in time for the last three months of fiscal 1953 (next April, May, June).

Dr. Rowntree said the Board felt the "gradual whittling away" of VA budgets both by the Budget Bureau and by Congress is lowering the quality of medical service and spreading a "sense of insecurity" among VA medical personnel.

The immediate problem is the $31 million (or 5 per cent) cut Congress made in the funds the Budget Bureau had approved for VA medical programs during the current year. VA already has announced it would have to reduce its average hospital patient load from 102,000 to 99,200.

VA has an acute problem. It is attempting to absorb its $31 million budget cut without laying off medical personnel—physicians, nurses and dentists. To get expenses of the Medical Department under the limitation set by Congress, about 3,000 hospital beds are being closed out and 6,000 positions eliminated. However, all professional personnel, according to VA, are being offered assignments elsewhere.

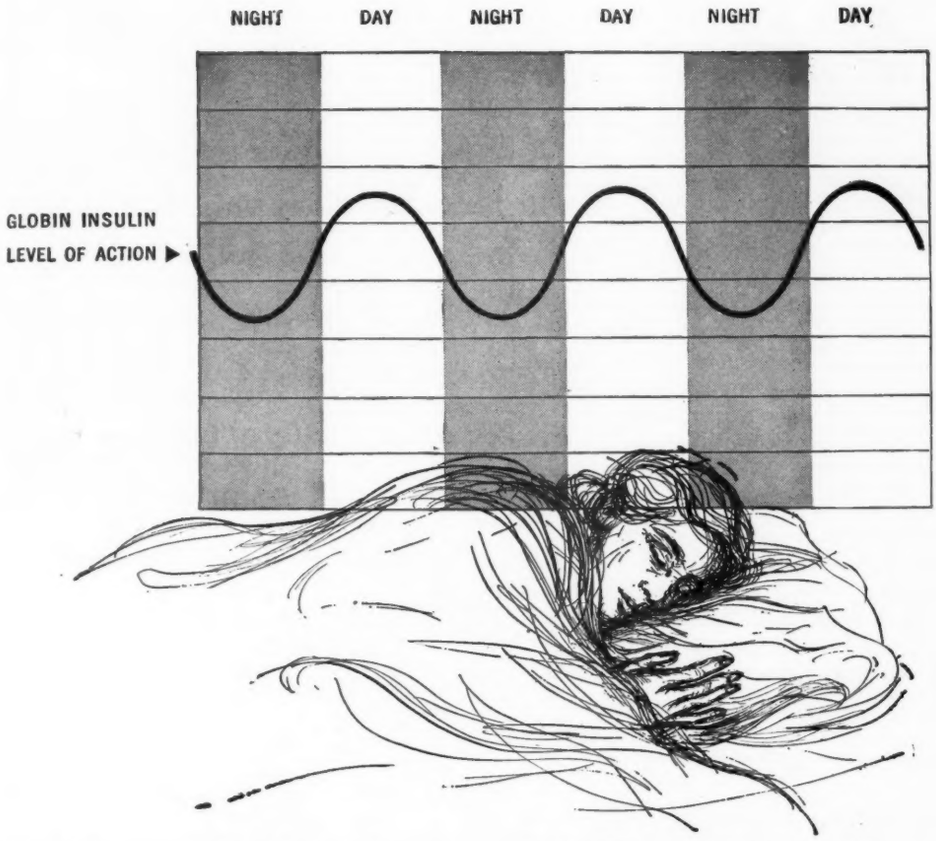
AMA *Washington News Letter*

HOW MANY HANDS ARE IN YOUR POCKET?

In these times, the salary check received by the average citizen is committed almost 100 per cent by the time he gets it—in some instances, of course, it is overspent. The mortgage on the house, the company that financed the automobile, the store that put in the TV set, the grocer who sends a bill once a month; all of these and others have their hands in the citizen's pocket. He doesn't see or handle any substantial sums of money any more; it is all paper work. As Clifford B. Reeves of Mutual Life says, there are only $268 of hard-earned money in the world—all the rest of it is accounting.

The net effect is that the average citizen is never much farther than three months from bankruptcy. He is in a financial position where a serious uninsured loss would ruin him. He is well aware of this. Conse-

(Continued on Page 1392)



Provide peaceful nights for many diabetics with intermediate-acting

Globin Insulin 'B. W. & Co.'®

Globin Insulin 'B.W. & Co.', given in one injection in the morning, acts promptly, sustains action during the day when it is needed most, tapers off during the night when hypoglycemic reactions might otherwise occur.

For many diagnosed diabetics think of Globin Insulin because it possesses the highly desirable intermediate-timing of action; furthermore accurate measurement of doses is uncomplicated since it is a clear solution.

40 units in 1 cc.	vials of 10 cc.
80 units in 1 cc.	vials of 10 cc.

'Wellcome'® brand Globin Insulin with Zinc

Burroughs Wellcome & Co. (U.S.A.) Inc., *Tuckahoe 7, N.Y.*

HOW MANY HANDS ARE IN YOUR POCKET?

(Continued from Page 1390)

quently he has turned to all forms of protection—prepaid hospitalization, life insurance, fire and casualty, inland marine, and anything else that he believes he needs to provide the security that he no longer is able to furnish out of his own situation. He achieves security as he purchases property, on the installment plan.

And it is not only the average citizen that has been infected by the amortization principle which makes it so easy to create property by spending futures—by borrowing money. At the other end of the economic scale the big corporations borrow huge sums to expand their operations, and they amortize their debt in the same manner, if not in the same size, as the average citizen. They also do not wait until they have saved up the money before spending it.

Many of us today live close to the brink of financial disaster. We have our jobs which are contingent upon our being able to perform satisfactorily in them. The salary checks that we get for doing the work are pretty well committed in advance. Taxes hamper the accumulation of money. These are some of the reasons why so many forms of insurance have ceased to be a matter of choice and have become things of necessity.—*The National Underwriter,* June 26, 1952.

FUTURE DATES FOR YOU

The **Michigan Clinical Institute** is scheduled for Detroit five years in advance as follows:

1953.....March 11-12-13
1954.....March 10-11-12
1955.....March 9-10-11
1956.....March 8- 9-10
1957.....March 13-14-15

The Annual Sessions of the **Michigan State Medical Society** are scheduled six years in advance, as follows:

1953.....September 23-24-25—Grand Rapids
1954.....September 29-30-October 1—Detroit
1955.....September 28-29-30—Grand Rapids
1956.....September 26-27-28—Detroit
1957.....September 25-26-27—Grand Rapids
1958.....Week of September 22—Detroit

* * *

The Annual MSMS Public Relations Conference will be held at the Sheraton-Cadillac Hotel on Sunday, February 1, 1953, following the three-day Annual Session of the MSMS Council.

The Annual County Secretaries Conference will be held at the Porter Hotel and at the MSMS headquarters in Lansing on Wednesday, February 25, 1953, following the one-day meeting in Lansing of Michigan's County Society Executive Secretaries.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

Jan. 16-17 Sixth Annual Michigan Rural Health Conference — Kellogg Center, East Lansing

Jan. 28 Mt. Carmel Mercy Hospital Clinic Day — Detroit

Feb. 1 MSMS Public Relations Conference — Sheraton-Cadillac Hotel, Detroit

Feb. 25 MSMS Annual County Secretaries' Conference — Porter Hotel, Lansing

Mar. 10 MICHIGAN INDUSTRIAL HEALTH DAY — Sheraton-Cadillac Hotel, Detroit

Mar. 11-13 MICHIGAN CLINICAL INSTITUTE — Sheraton-Cadillac Hotel, Detroit

Mar. 13 Fourth MICHIGAN HEART DAY (part of MCI) — Detroit

Spring MSMS Postgraduate Extramural Courses — Statewide

April 8 Genesee County Medical Society 9th Annual Cancer Day — Flint

April Jackson County Medical Society's Clinic Day — Jackson

April Highland Park Physicians Club Clinic — Highland Park

May 7 Ingham County Medical Society's Clinic Day — Lansing

May 13 Wayne University Medical Alumni Clinic Day and Reunion — Hotel Fort Shelby, Detroit

May 21 The American College of Surgeons Annual Symposium on Trauma and Nutrition — Detroit

June 1-5 AMA Annual Session — New York

June 2 Annual Clinic Day, Bon Secours Hospital — Detroit

June Upper Peninsula Medical Society Annual Meeting — Escanaba

July 30-31 Annual Coller-Penberthy Medical Surgical Conference — Traverse City

August Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties — Grayling

Sept. 22 Michigan Chapter, American College of Surgeons — Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION — Grand Rapids

October Michigan Cancer Conference — East Lansing

Autumn MSMS Postgraduate Extramural Courses — Statewide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Famous Beaumont Painting Presented to MSMS by Wyeth, Inc.

WYETH EXECUTIVE PRESENTS CORNWELL WORK
Stuart V. Smith *(left)*, Vice President of Wyeth, Inc., Philadelphia, points out a detail of the Dean Cornwell painting, "Beaumont and St. Martin," to Otto O. Beck, M.D. *(center)*, Birmingham, 1951-52 MSMS President, and to Harry J. Loynd *(right)*, Detroit, President of Parke, Davis & Company. Wyeth, Inc., presented the valuable painting to MSMS on September 23, 1952. It will hang in the Beaumont Memorial building on Mackinac Island.

The beautiful Dean Cornwell painting "Beaumont and St. Martin" depicting a highlight in the history of medicine—which had its beginnings in Michigan—was presented to the Michigan State Medical Society by Wyeth, Incorporated, the Philadelphia pharmaceutical house, on September 23, during the 1952 MSMS Annual Session in Detroit.

The presentation was made by Stuart V. Smith, Senior Vice President of Wyeth, Inc., and was accepted by President Otto O. Beck, M.D., Birmingham, in behalf of the State Medical Society (See page 1417).

A great-grandniece of Dr. William Beaumont, Mrs. George L. Stokes of Flint, unveiled the Beaumont painting.

Assisting in the ceremonies were D. J. Withington, Vice President, and Robert G. Wilder, Public Relations Counsel of Wyeth. Aiding President Beck were A. H. Whittaker, M.D., Detroit, Chairman of the MSMS Beaumont Memorial Restorations Committee, and J. E. Livesay, M.D., Flint, a long-time friend of the historically important Stokes family.

The "Beaumont and St. Martin" painting temporarily will hang in the MSMS headquarters at 606 Townsend, Lansing, until its permanent "home," the Beaumont Memorial to be erected by Michigan doctors of medicine on Mackinac Island, is completed. The dedication ceremonies are tentatively set for July, 1954.

The Beaumont Memorial will be carefully erected on the site of the American Fur Company store

(Continued on Page 1396)

(Continued from Page 1394)

on Mackinac Island where the blast of a musket saved a million lives. This restoration, to cost the medical doctors of Michigan some $40,000, will be given to the people of the State of Michigan as an historical memorial.

In this original American Fur Company store, the French-Canadian voyageur, Alexis St. Martin, accidentally was wounded in his side in 1822. The wound left an opening in the man's stomach through which William Beaumont, M.D., a surgeon at nearby Fort Mackinac, could observe the action of the gastric juices.

The story of Dr. Beaumont and Alexis St. Martin is an historical tale of drama and medical discovery in an age when the science of medicine was as primitive as the locale of Mackinac Island.

Dr. Beaumont's important medical discovery began on June 19, 1822, when an accidentally discharged musket caused a gaping wound in St. Martin's side; Beaumont was certain the young voyageur could not live through the day. But St. Martin lived with a hole in his side; he lived with a gastric fistula through which Dr. Beaumont studied the actions of the stomach's digestive process; with this human test tube, Dr. Beaumont was able to determine the role of emotion in digestion.

His experiments on the gastric juices are monumental in the history of medicine; until that time, little was known of how food was digested. Dr. Beaumont's contributions to medical science rank with Harvey's discovery of the circulation of the blood and are rated above the famed experiments of Ivan Petrovich Pavolov which contributed to the knowledge of the physiology of digestion.

Parke, Davis & Co. Purchase Land for Memorial

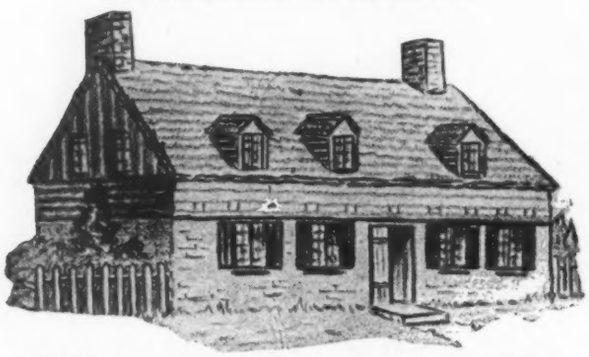
The initial contributions for the purchase of the land for the Beaumont Memorial was made by Parke, Davis & Co. of Detroit through the interest and dynamic co-operation of W. F. Doyle, Lansing, Chairman of the Mackinac Island State Park Commission. The Park Commission has agreed to maintain the Memorial in perpetuity.

The Michigan State Medical Society already has commissioned the famous Professor Emil Lorch of Ann Arbor to be the architect in the erection of the Beaumont Memorial. Members of the Consultative Committee and of the Working Committee to aid with the details of construction, include: Otto O. Beck, M.D., Birmingham; F. A. Coller, M.D., Ann Arbor; Prentiss M. Brown, Detroit; L. J. Hirschman, M.D., Traverse City; Professor Emil Lorch, Ann Arbor; Harry J. Loynd, Detroit; A. H. Whittaker, M.D., Detroit; W. S. Jones, M.D., Menominee; D. Hale Brake, Lansing; J. Joseph Herbert, Manistique; A. N. Langius, Lansing; G. B. Saltonstall, M.D., Charlevoix; William Bromme, M.D., Detroit; W. F. Doyle, Lansing, and L. Fernald Foster, M.D., Bay City.

The work of bringing the Beaumont Memorial to a reality for the people of the State of Michigan has been and is being done by members of the Michigan State Medical Society. It is a project that will inure permanently to the credit of Michigan's medical men. The public by the hundreds of thousands who visit Mackinac Island in future endless summers will read a plaque that gives credit to the M.D.'s of Michigan for their tangible efforts in extending credit to one of their own immortal men of science.

Proposed

BEAUMONT MEMORIAL



"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

Beaumont Memorial Restoration Committee
Box 539, Lansing 3, Michigan

I attach my check in the amount of: $.....
OR
I pledge the amount of: $.....

payable on or before .....
to assist my fellow doctors of medicine of Michigan in building the Beaumont Memorial on Mackinac Island, Michigan.

..... **M.D.**

.....
street

.....
city **state**

protein?

60%

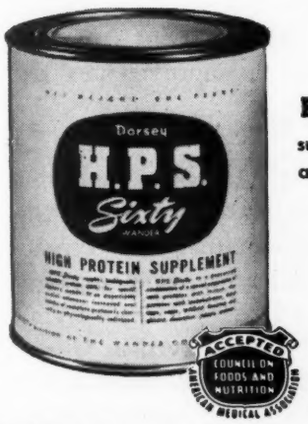
yet as acceptable to the patient as a tasty milk shake

When the protein intake must be increased beyond the amount an acceptable diet can supply, **H.P.S.** *Sixty* proves especially valuable. Providing 60% protein, 1.5% fat, and 27% carbohydrate, it makes a delightful beverage with water or milk, readily acceptable to the patient even when anorexia prevails.

Prepared with water according to directions (6 oz. water, 1½ oz. **H.P.S.** *Sixty*), three servings daily furnish 77 Gm. of biologically complete protein. When skim milk or whole milk is used instead of water, three servings provide 96 Gm. or 95 Gm. of protein respectively.

H.P.S. *Sixty* is processed from milk protein concentrate, soy protein, whole egg powder, powdered sugar and flavoring. Its proteins are intact; hence it is not burdened by objectionable odor. Valuable for use when whole protein can be utilized, **H.P.S.** *Sixty* may be indicated in the dietary management of undernutrition, peptic ulcer, hepatitis, chronic diarrheal states, pregnancy and lactation, and following burns and other injuries which raise the protein needs. Caloric equivalent, 3.6 per Gm., 102 per ounce.

SMITH-DORSEY • Lincoln, Nebraska A Division of THE WANDER COMPANY



H.P.S. *Sixty* supplied in 1 lb. and 4 lb. tins.

H.P.S. *Sixty*®

A *Dorsey* PREPARATION

Cancer Comment

MSMS CANCER CONFERENCE ATTENDANCE RECORDS BROKEN

F. L. Rector, M.D.

The Fourth Michigan Cancer Conference, primarily sponsored by the MSMS Cancer Control Committee, was held at the Kellogg Center for Continuing Education, East Lansing, on October 9, and drew an attendance of more than 300. This was an increase of over 100 more than attended any previous session.

The Conference was held in co-operation with the Annual Training School of the Michigan Division, American Cancer Society; it also was sponsored by the Michigan Department of Health.

L. E. Holly, M.D., of Muskegon, presided.

R. J. Hubbell, M.D., President, Michigan State Medical Society, welcomed the delegates and discussed "Some Aspects of the Cancer Problem in Michigan." C. Allen Payne, M.D., Grand Rapids, spoke on the question: "Is Progress Being Made in Cancer Control?" Freddy Homburger, M.D., of Boston, Massachussetts, reviewed "Cancer Diagnostic Tests." Otto K. Engelke, M.D., of Ann Arbor, gave his views on "The Local Health Department's Responsibility in Cancer Control." Miss E. Margaret Siebert of Lansing discussed "Cancer Control—The Price and the Payoff"—with a plea for individual interest in the cancer control problem.

A luncheon was held immediately following the morning program at which Horace Wray Porter, M.D., of Jackson, presided. Questions from the audience were answered by the morning speakers.

Dr. Rector Honored

Frank L. Rector, M.D., Lansing, long-time active in cancer education and Secretary of the MSMS Cancer Control Committee, was signally honored at the luncheon. A leather, gold engraved briefcase was presented to him by Horace Wray Porter, M.D., Jackson, who had served as Chairman of the MSMS Cancer Control Committee for the past two years. The following eulogistic statement was read by MSMS President Hubbell:

GREETINGS and congratulations to Frank L. Rector, M.D., from the undersigned on the publishing of the "Cancer Manual for High School Students" and in sincere appreciation of twenty-two consecutive years in cancer education in Michigan, the last six of which have been spent as the never failing secretary of the Cancer Control Committee of the Michigan State Medical Society.

We recognize your outstanding record in cancer education in the United States, particularly in Michigan, and your exceptional ability as a secretary whose meticulous attention to detail, continuous rhetorical perfection and unexcelled memory for names, faces, facts and figures makes you the invaluable asset that you have been to the Cancer Control Committee.

On this premier publication day of your Cancer Manual, on which you spent years in careful and painstaking editorial preparation, we salute you. It has been a pleasure and a privilege to have served on this committee under your secretarial service.

The scroll was signed by members of the MSMS Cancer Control Committee and other friends of Dr. Rector.

TREATMENT OF CANCER

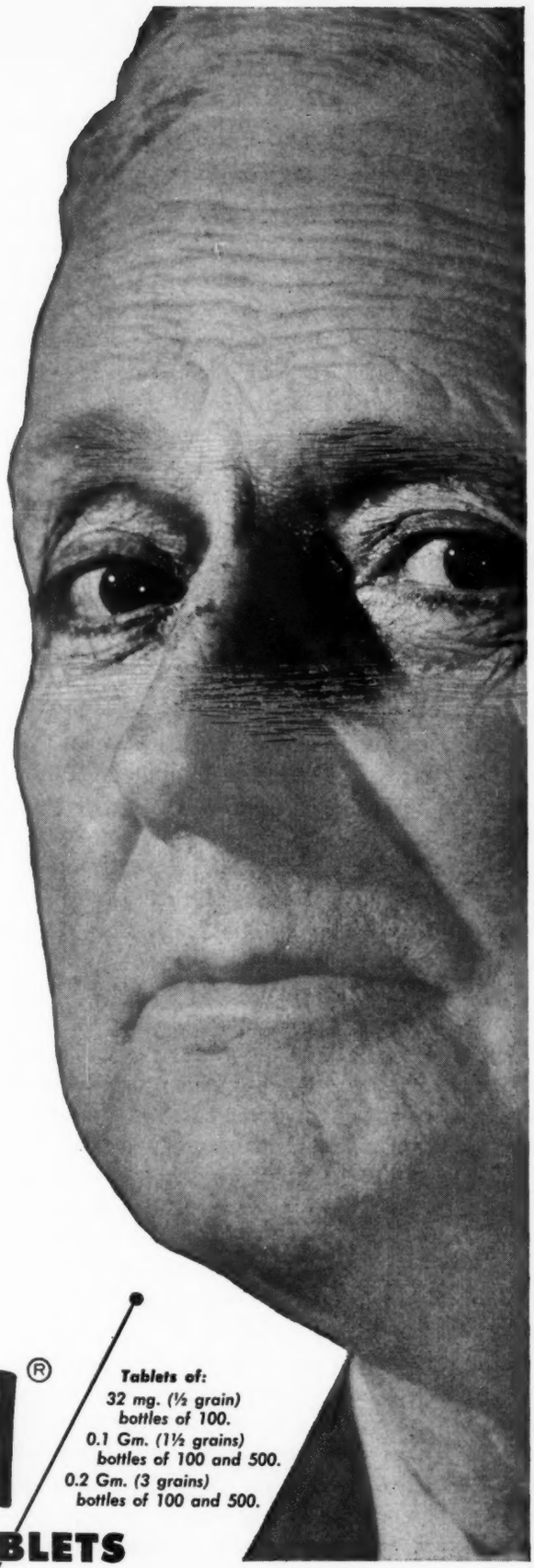
The increasing emphasis being placed on cancer research is producing therapeutic measures that give promise of value in the cancer field. It must be emphasized, however, that in no case has an agent effective against all forms of cancer been discovered. Those now known and worked with usually are confined in their activities to one or two types of the disease and on these they exert only a palliative effect and then often only in one sex.

In surgical treatment the area of operability has been extended by blood and electrolyte transfusions, by better control of infections and safer anesthetics. Mutilation is sometimes extensive and postoperative activities of the individual markedly curtailed.

In the radiological therapy of cancer, much progress has been made in two directions: (1) in

(Continued on Page 1400)

Relaxed but awake



In emotional and nervous disorders, Mebaral exerts its calming influence without excessive hypnotic action.

Mebaral is also a reliable anticonvulsant.

INDICATIONS:

Because of its high degree of sedative effectiveness, Mebaral finds a great field of usefulness in the regulation of agitated, depressed or anxiety states, as well as in convulsive disturbances. Specific disorders in which the calming influence of Mebaral is indicated include neuroses, mild psychoses, nervous symptoms of the menopause, hypertension, hyperthyroidism and epilepsy.

Mebaral®

Tasteless **TABLETS**

Tablets of:
32 mg. (½ grain) bottles of 100.
0.1 Gm. (1½ grains) bottles of 100 and 500.
0.2 Gm. (3 grains) bottles of 100 and 500.

WINTHROP-STEARNS INC. New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

TREATMENT OF CANCER

(Continued from Page 1398)

enabling a heavier dosage of radiation to be delivered to the cancerous growth through improved methods of focusing the radiation on the malignant growth; and (2) the use of radioactive chemicals with a special selectivity for certain tissues; viz.:—radioactive phosphorus for bone lesions and radioactive iodine for cancer of the thyroid gland. Radioactive cobalt also is assuming increasing importance in cancer therapy.

The recent installation of a 50-gram radium "bomb" in an eastern hospital has brought into use a greater amount of radium than has ever before been assembled for cancer therapy. Reports of its use will be watched for with keen interest by all radiologists.

The search for effective anti-cancer chemicals is being pursued with great intensity. A few, like the nitrogen mustards, have caused temporary remissions in lymphoblastomas and leukemia. Folic acid antagonists, ethyl carbamate and stilbamidine are among the chemicals that have given encouraging results when used on certain types of cancer. Cortisone is without permanent benefit although in certain phases of chronic leukemia it gives helpful palliation. The list of such chemicals being investigated is an extensive one.

No blood or other body fluid test for cancer has any reliability for general use. Such "tests" are the stock in trade of the average cancer quack and charlatan, who often claims that by such tests he can not only diagnose cancer but also can determine precancerous conditions.

In spite of all the publicity about new cancer "cures" coming from the research laboratories via the pages of newspapers and lay magazines, the only *curative* methods generally available to the clinician are surgery and irradiation, used either together or separately.

Many stories have been printed in which claims are made that a new "cure" has been found. All too often these reports are based on laboratory animal tests or, at the most, on one or a very few human patients. Often the reported results are but one step or phase of a larger research program and have little significance when additional information comes to light about the problem as a whole. The fact that no subsequent report ever is made on many of these "tests" and "cures" establishes their worthlessness as reliable therapeutic measures.

The unwarranted premature publicity about cancer diagnostic measures and curative procedures, as well as the false propaganda of the unprincipled quack and charlatan, lead many cancer patients to refuse accepted scientific methods of treatment or delay treatment in the hope of impossible cures through propagandized methods. Both situations work incalculable harm to the public and the cancer patient. They also aggravate public criticism of the medical profession for refusing to utilize such methods in treatment of their cancer patients. Physicians should not hesitate to point out to their patients and to the public the inconclusive results on which premature claims are based and the harm that would result from their indiscriminate use in cancer therapy.

An aspiration or needle biopsy is not a satisfactory method for obtaining a biopsy of a breast lesion.

* * *

Actual surgical biopsy with immediate frozen section followed by radical mastectomy is the proven method of management of cancer of the breast.

* * *

Observation of of a breast tumor should be limited to a period of two to four weeks to observe effect of cyclic changes or to observe a possible inflammation.

Heart Beats

MEMBERSHIP IN THE MICHIGAN HEART ASSOCIATION

The Michigan Heart Association, which was formed by a committee of the Michigan State Medical Society, extends a cordial invitation to all medical doctors to become active members in the Association. Membership is open to any medical doctor who is interested in the objectives and work of the organization. For those who may not be familiar with these objectives, the Association's Articles of Incorporation state that it was formed for the following purpose: ". . . the acquisition, dissemination and application of knowledge concerning the normal heart and circulation, and the causes, diagnosis, prevention and treatment of disorders of the circulation and diseases of the heart, blood vessels and lymph vessels . . ."

How well the Michigan Heart Association has adhered to these objectives is accurately recorded in the more than $185,000.00 which has been allocated by the Association during the past three years for thirty-five research studies into diseases of the cardiovascular system. This money has been provided to medical schools, hospitals and other institutions in Michigan and represents more than one-half of the total amount of monies received by the Heart Association to date from United campaigns throughout the State.

In addition to its comprehensive program of research, the Michigan Heart Association has provided funds for several education and community service projects including: major financial support of the Michigan State Medical Society's Rheumatic Fever Control Program; expansion of a professional education program designed to keep the Doctor of Medicine in Michigan informed of the latest scientific advances in diagnosing, treating and controlling heart disease; development of an effective public education program; development of a program of time and energy conservation for the homemaker whose work capacity is limited by heart disease; intensified studies in industry to increase job opportunities for heart patients; participation in Michigan Health Council projects, and many others.

One of the major activities of the Association's professional education program is the Annual Heart Day Program, which is held each year in conjunction with the Michigan State Medical Society's Clinical Institute. The 1953 Heart Day has been scheduled for Friday, March 13, and will feature the presentation of papers concerned with the latest information on heart research work.

In addition to these projects, the Michigan Heart Association provides financial aid to the American Heart Association for heart research and education throughout the nation.

Active membership in the Association entitles you to subscriptions to a total of four different publications dealing with cardiovascular diseases, depending upon the type of membership which you choose. The latest addition to this list of publications is a bi-monthly journal entitled *Circulation-Research*. This journal will deal mainly with basic science reports in the cardiovascular field, and the monthly Journal, *Circulation*, will be devoted exclusively to work of clinical usefulness. *Modern Concepts of Cardiovascular Disease* is a monthly publication, and is a condensed review of the latest thinking on specific topics within the cardiovascular field. The fourth publication is *The American Heart Quarterly* which carries informative "news article" type of information on heart diseases.

If you are interested in membership in the Michigan Heart Association and if you would like to share in its numerous programs and activities, clip and mail the following coupon today for full information on all types of membership.

TO: Michigan Heart Association
4421 Woodward
Detroit 1, Michigan

Please send me complete information on membership in the Michigan Heart Association. I am interested in the following publications:

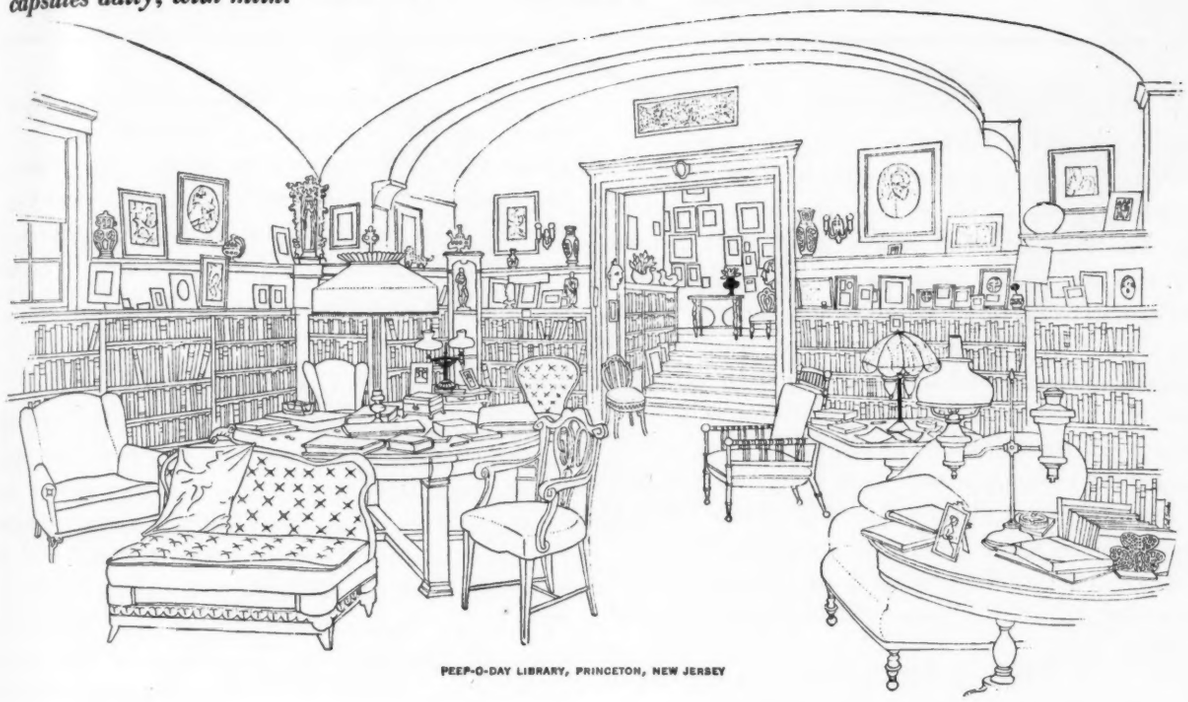
- ☐ Circulation
- ☐ Circulation-Research
- ☐ Modern Concepts
- ☐ American Heart Quarterly

..... M.D.

.....
(Street Address)

.....
(City)

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



PEEP-O-DAY LIBRARY, PRINCETON, NEW JERSEY

a low cost antibiotic in the broad-spectrum field is

AUREOMYCIN

Hydrochloride Crystalline

because

Low dosage of aureomycin has very frequently been reported in the literature to be entirely effective.

Small amounts of aureomycin may reduce disability, or hospital stay, to a few days.

Early use of aureomycin may forestall those failures that have been reported in the literature following penicillin and streptomycin.

The proven range of clinical usefulness of aureomycin is so wide that, when clinical diagnosis is established, prolonged and costly laboratory studies are largely unnecessary.

Capsules: 50 mg.—Vials of 25 and 100.
100 mg.—Vials of 25 and bottles of 100.
250 mg.—Vials of 16 and bottles of 100.

Ophthalmic Solution: Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

AMA News Notes

TV SHOWS TO HIGHLIGHT DENVER MEETING

Plans are being made to present two half-hour network television shows covering high points of the American Medical Association's sixth annual Clinical Session in December. Originating from Denver, the telecasts will highlight Session activities, including presentations of new surgical and clinical demonstrations, special scientific exhibits and other interesting medical features. The programs will be of interest to physicians who cannot attend the meeting as well as to the general public.

Present plans call for coast-to-coast coverage on two different nights during the meeting, December 2-5. Once again the programs are being sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

RURAL HEALTH CONFERENCE SET FOR FEBRUARY 27-28

"Widening the Highway to Health" will be the theme of the eighth national Conference on Rural Health to be held February 27-28, 1953, at the Roanoke Hotel, Roanoke, Virginia. The day preceding the general sessions (February 26) will be devoted to an informal get-together of physicians who are responsible for rural health programs in their respective states, to discuss "Doctor Participation in Community Programs."

The subject of financing rural medical care will be covered at Friday's sessions. An experience-and-accomplishment program to stimulate thought on "What Can I Do When I Get Home?" will be presented the last morning. The final luncheon speaker will tell what medicine is doing, in cooperation with other organizations and groups, to help America solve its health problems.

NEW RADIO SERIES ON SPORTS AND HEALTH

A new series of radio transcriptions dealing with sports and health subjects will be available about December 15, from the AMA's Bureau of Health Education for use by local radio stations. The programs are based upon on-the-scene interviews with Olympic winners in Helsinki, Finland, and with national champions and other outstanding sports figures in this country.

Topics cover personal aspects, athletic accomplishments, team practice and health values of sports. Among those interviewed were Bobby Brown, M.D., of the world's champion New York Yankees; Harrison Dillard, Olympic 100-meter hurdling champion, and Julius Boros, world's national golf champion.

PR CONFERENCE IN DENVER

The AMA's fifth annual National Medical Public Relations Conference will be held Monday, December 1—the day before the opening of the Clinical Session—at the Shirley-Savoy Hotel, Denver. Theme of the one-day meeting will be "Mutual Understanding . . . the Key to Better PR." The Conference program will be geared primarily for physicians. Members of the House of Delegates, officers of state and county medical societies, officers of the Association and executive secretaries and PR personnel are cordially invited.

NATIONAL CONFERENCE ON TRICHINOSIS

The American Medical Association has joined with the U.S. Public Health Service, the U.S. Bureau of Animal Industry, the American Public Health Association and the American Veterinary Medical Association in sponsoring a National Conference on Trichinosis. The meeting is scheduled for December 12, at AMA Headquarters, Chicago.

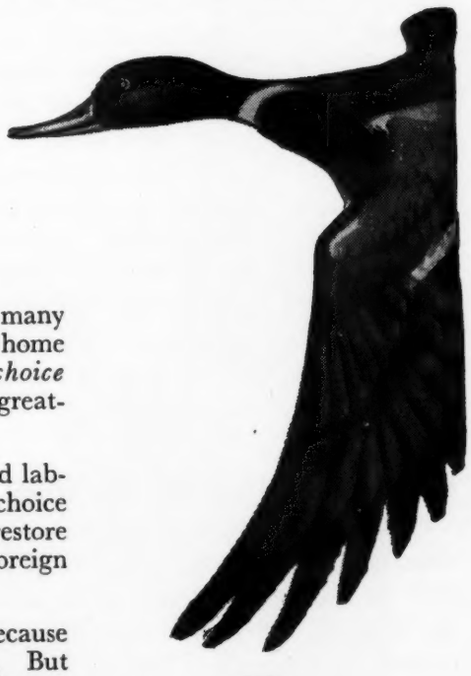
It is hoped that the Conference will stimulate interest in the need for further public education on the dangers of trichinosis. Doctors Leonard W. Larson, Bismarck, and J. J. Moore, Chicago, were appointed AMA representatives by the Board of Trustees.

RURAL HEALTH RADIO SERIES AVAILABLE

An eight-week radio transcription series on rural health entitled "Help Yourself to Health" was released October 15, by the AMA's Bureau of Health Education to state and county medical societies. The series consists largely of true stories about small American communities which have successfully solved their health problems through

(Continued on Page 1406)

"THERE'S ALWAYS A *Leader*. . . . . MALLARD, INC."



Due Partly to a Tea Party 179 Years Ago

The revolution that followed the Boston Tea Party many years ago was fought against dictation by anyone at home or abroad. Here at Mallard we feel that *freedom of choice* is one of the important American Freedoms our great-great-grandfathers won.

Freedom of choice lets us choose finest ingredients and laboratory controls in our manufacture. Freedom of choice lets you seek the pharmaceuticals you feel will best restore your patients' health. There is no ruling edict by a foreign commissar.

We're convinced the American people benefit because you are absolutely free to prescribe their medicinals. But maybe we are predjudiced. It's your freedom that allowed you to choose Mallard for over 40 years. Thank you.

Karl O. Mallard

Karl O. Mallard
President, Mallard, Inc.

MALLARD
INC.
DETROIT 16, MICHIGAN

RURAL HEALTH RADIO SERIES AVAILABLE

(Continued from Page 1404)

local initiative and effort. Citizens from these communities tell the stories in their own words.

Verbatim comments used in the transcriptions were tape-recorded at the National Conference on Rural Health held in Denver. The series was produced by the Rocky Mountain Radio Council. Each program runs fifteen minutes.

Covered in the series are such vital topics as "How Small Towns Can Get a Doctor," "How Small Towns Can Keep a Doctor," "Training Rural Doctors," "Working Together for Health" (health councils) and "Projects for Your Health Council." The theme that "self-help is the American way" runs throughout the programs.

FIRST AID GUIDE NOW AVAILABLE

Useful tips on how to handle common first aid emergencies have been compiled in a pocket-sized manual by the AMA's Council on Industrial Health and the Bureau of Health Education. The booklet outlines adequate first aid instructions for everyday illnesses and injuries in a simple way. It is designed to guide those who have not received formal first aid training as well as to refresh the memories of the experienced. A list of suggested items for a first aid kit also is included.

Single copies are available without charge through either of these AMA departments. Quantity prices will be supplied on request by the Order Department.

STUDENT AMA ANNUAL MEETING

Outstanding leaders in medicine and medical education will be featured on the program of the 1952 annual session of the House of Delegates of the Student American Medical Association December 29-30, at the Sheraton Hotel, Chicago.

Dr. Walter C. Alvarez, Chicago, will speak December 30, on "The Disappearing Art of Diagnosing with the Eyes and Ears." John Van Nuys, M.D., dean, Indiana University School of Medicine, will be the principal luncheon speaker the same day, discussing "A Dean and His Problems."

Also included on the intensive two-day schedule will be a luncheon given by the Blue Shield Medical Care Plans and a buffet supper by Abbott Laboratories of North Chicago.

It is hoped that state and county medical societies will lend enthusiastic support to local chapters of the SAMA by making sure that they are represented again this year.

STATES' MEDIATION COMMITTEES

The AMA Council on Medical Service reported at a recent meeting at AMA headquarters that mediation committees had now been set up in each of the forty-eight states, the District of Columbia, and Hawaii, marking a major milestone in the medical care program for the United States.

This is the result of an intensive four-year campaign on the part of the medical profession for the creation of such patient-physician relations bodies throughout the country.

This fact became known as reports were received from the chairmen of seven committees, each dealing with a specialized field of medical care. Other highlights from these reports, presented at a two-day meeting of the council, were:

(1) Voluntary health coverage continues to gain both in quality and quantity. There are ample reasons to predict that 90 million persons will be covered by some form of protection against the costs of illness, accident and hospitalization in 1953.

(2) Community health councils have increased from forty-eight local health councils in 1943 to 1,190 in 1951, showing a substantial increase during the past year. Twelve indigent medical care studies have been made under the direction of the council, and plans are under way for an additional nine studies. Placement services for physicians have been established in thirty-seven states. Approximately 600 emergency call programs are now in operation throughout the United States.

The committee chairmen making the reports were: Drs. Ralph A. Johnson, Detroit, physician placement services; H. B. Mulholland, Charlottesville, Va., indigent medical care; W. L. Crawford, Rockford, Ill., maternal and child care; W. A. Sawyer, Rochester, N. Y., industrial workers; Percy E. Hopkins, Chicago, prepayment, and F. J. Elias, Duluth, health co-operatives.

The greatest possibility for improvement of results in the treatment of gastric carcinoma, other than earlier diagnosis, is more aggressive surgical intervention.

More Contributions to AMEF

Following are the names of the doctors of medicine, alumni of the College of Medicine of Wayne University, who have contributed (up to September 30, 1952) to the Medical Library Fund, for which they receive credit from the American Medical Education Foundation. About $87,000 from about 600 contributors has been received:

Cecil Akroyd, Herman Albrecht, Elvis S. Alford, B. T. Alm, Sam Alpiner, Robert L. Alznauer, George H. Andries, Raymond C. Andries, L. Byron Ashley, Lawrence R. Atler, Don A. Bailey, Louis J. Bailey, W. Claire Baird, Frank T. Balaga, M. A. Balcerski, Radivoj Ray Barber, Benjamin Barenholtz, Morton Barnett, William H. Barron, A. Duane Beam, Donald C. Beaver, C. L. Becklein, Morris C. Beckwitt, W. George Belanger, Roland R. Benson, Frederick E. Bentley, Charles J. Berger, Joseph H. Bergin, Ivan C. Berlien, Gerald J. Bernath, Bernard Bernbaum, Albert E. Bernstein, Montrose M. Bernstein, Robert J. Bernucci, Leonard Birndorf, Alexander W. Blain, Alexander Blain, III, James H. Blain, Jr., Alfred Bleier, Joseph Bleier, Abraham Bloch, Elliss J. Bolan, Ephraim B. Boldyreff, Ralph H. Bookmyer, Robert M. Bookmyer, Sidney Bornstein, Roman E. Boucher, Walter H. Boughner, Edwin G. Bovill, Horace F. Bradfield, Lionel Braun, Viola G. Brekke, William B. Bremer, M. S. Brent, Norman W. Brey, William J. Briggs, Osborne A. Brines, Clark D. Brooks, R. A. Brown, Reeve M. Brown, Earl Brubaker, Edwin L. Bruer, Donald R. Bryant, Henry Burkhardt, D. H. Burley, Robert T. Burns, Perry P. Burnstine, Roswell G. Burroughs, Samuel A. Butler, Edward J. Buttrum.

Anthony D. Calomeni, Duncan A. Cameron, Alexander M. Campbell, Clarence L. Candler, Edward K. Carmichael, James G. Carr, Herman J. Carson, C. W. Castrop, Constantine A. Cetlinski, Henry G. Chall, Louis H. Chamberlin, Henry A. Chapnick, William P. Chester, Zolton B. Cigany, I. Muir Clapper, Frank H. Clark, Raymond L. Clark, Ronald E. Clark, C. H. Clausen, John E. Clifford, T. Percy Clifford, Julius C. Clippert, B. C. Clyne, Leon F. Cobb, Herbert H. Cohen, Don A. Cohoe, Fred H. Cole, James E. Cole, Clifford W. Colwell, S. E. Condon, John Patrick Connolly, George V. Conover, Henry Cook, James A. Cook, Benjamin F. Cooper, George W. Cooper, Henry O. Coucke, Robert Cowen, Harley C. Crane, Kenneth L. Crawford, Maurice Croll, Richard C. Crowell, Victor Curatolo, Paul L. Cusick.

Esther H. Dale, Harold M. Dana, Clifton L. Dance, Charles E. Darling, James E. Davis, Writ A. Dawson, Stella M. Delaini, N. DelZingro, John S. DeTar, Edwin F. Dittmer, Ray S. Dixon, H. C. Dodds, Charles F. Dodenhoff, James R. Doty, Ira G. Downer, W. M. Drake, Harold I. Drinkaus, Joseph J. Dubin, Lloyd S. Dunkin, Cornelius E. Dunn, C. I. Dutchess, Herbert L. Eastman, Irving I. Edgar, Robert B. Edmonson, Harry R Eggleston, Thomas N. Eickhorst, E. F. Eldredge, Robert J. Elridge, Elizabeth Endicott, Alwyn A. Engelman, Clayton J. Ettinger.

F. R. Felt, William G. Fenner, Meryl M. Fenton, Stanley C. Fenton, Carl A. Fettig, F. Sinclair Finch, Theodore Finkelstein, Cornelius J. Fisher, Andrew O. Fitzmorris, Norman W. Flaherty, Richard O. Flett, Robert G. Fogt, H. S. Foley, Walter D. Ford, Melvin E. Fowler, John W. Fox, Paul L. Fraiberg, Charles Jackson France, Mary Margaret Frazer, Wilmer Freeman, J. Courtney Fremont, Alex S. Friedlaender, Sidney Friedlander, David Friedman, Lyle W. Frost, James D. Fryfogle.

Lawrence W. Gardner, Ormond D. Geib, Oscar P. Geib, R. E. Gibson, David Gigliotti, Ralph M. Gignac, Stephen M. Gillespie, Robert W. Gillman, W. A. Gilpin, Arthur M. Ginzler, Perry C. Gittins, William F. Goins, Morris I. Goldin, Bernard J. Goldman, Perry Goldman, S. S. Gorne, Edmond J. Gostine, Frederick D. Goudie, Raymond S. Goux, Warren Goux, Robert Greenidge, Wm. T. Greenlee, S. L. Grekin, Sol C. Grossman, Julius J. Gutow, A. B. Gwinn.

L. P. Haefele, Norman K. H'Amada, William Hamilton, George A. Hanna, Frederick E. Hansen, Roman W. Harkaway, Harold H. Harris, Robert K. Hart, Henry H. Hartkop, Wilfrid Haughey, John E. Hauser, Louis F. Hayes, Leonard P. Heath, Lyle E. Heavner, Harold Heffron, Hugh W. Henderson, Benjamin E. Henig, Dan R. Herkimer, Harold J. Hertz, Stanley A. Heyner, Stephen Lee Hileman, Walter T. Hileman, S. J. Hillenberg, Louis J. Hirschman, Harold H. Hiscock, Donald V. Hobbs, Charles L. Hodge, Henry A. Hoffman, Austin Z. Howard, Elston Huffman, Arthur R. Hummel.

S. D. Jacobson, J. L. Jaffee, J. R. Janney, Albert C. Jaslow, Benjamin Jeffries, Elwood A. Jenkins, Emil Jobb, Albert Johnson, W. L. Jones, Samuel J. Joseph, Benjamin Juliar.

Arnold Henry Kadish, R. Robert Kallman, Frank A. Kane, N. J. Kapetansky, Harry H. Kay, Morris Kazdan, J. B. Kearney, Clifford E. Keeler, Karl H. Kellogg, Herbert A. Kelman, Louis C. Kent, Fanny H. Kenyon, Wheeler H. Kern, William V. Kerwin, C. R. Keyport, Edward D. King, Melbourne J. King, Paul A. Klebba, John A. Kleber, Howard A. Klein, Joseph K. Klosowski, Byron S. Knapp, Donald A. Koch, C. S. Kogut, W. C. Kools, Adam W. Kossayda, Clifford S. Kozlow, Lester Kraft, Harley L. Krieger, Francis S. Kucmierz, Albert A. Kuhn, S. Walter Kuipers, Edward Kupka, S. A. Kwasiborski.

Walter E. Larson, Frederick R. Latimer, K. E. Latterell, Norman Lavine, R. C. Leacock, Louis S. Leipsitz, James J. Lentine, Willard R. Lenz, S. E. Lerman, Marvin B. Levy, S. M. Lewis, R. S. Libke, Hartman A. Lichtwardt, Abraham R. Lincoln, Harry R. Lipton, Edgar C. Long, Edwin H. Lorentzen, James M. Love, Henry A. Luce, Frederick E. Luger, H. B. Lustigman.

R. Sullivan McClinton, Robert W. McClure, Joseph A. McGarvah, Nicholas D. McGlaughlin, Joseph M. McGough, A. J. McGregor, J. Earl McIntyre, William B. McIntyre, D. W. McLean.

Orrin P. MacDougal, W. W. MacGregor, Walter H. Mack, Earle MacKenzie, Lewis Maire, Joseph H. Maltzer, Joseph M. Markel, Wolfgang H. Markgraf, Ben Marks, A. R. Marsh, R. G. B. Marsh, Robert G. Martin, Edgar E. Martmer, Glenn E. Mathias, Frederick M. Maynard, Hellmuth A. Meinecke, Herman A. Meinke, Harry E. Meisner, Hymen S. Mellen, Maxim P. Melnik, Walter Mercer, Elmer H. Merrill, W. F. Mertaugh, Hugh H. Miley, Daniel H. Miller, John J. Miller, Perry L. Miller, Georgia V. Mills, Robert C. Moehlig, George Mogill, S. Albert Molle, Robert Monfort, Joseph R. Montante, Benjamin T. Montgomery, W. S. Montgomery, William W. Moon, Sheffick John Moroun, Max M. Mosen, Nathan H. Moss, Colin D. Munro, A. P. Murphy, Scipio G. Murphy, Paul H. Muske.

A. E. Naylor, John F. Naz, Walter Neeb, George F. Newman, Kenneth C. Nickel, Warren O. Nickel, Kenneth Noble, Hal Norgaard, Joseph I. Nosanchuk.

Robert T. Obi, E. J. O'Brien, Edwin E. Olin, Cyrus F. Oman, Joseph M. Oppenheim, Milton Oppenheim, Charles Ornstein, Clarence I. Owen.

John Harold Packer, Alice E. Palmer, Hayden D. Palmer, G. A. Parillo, John W. Parnell, Harry A. Paysner, Marjorie Peebles-Meyers, George V. Pendy, John M. Pendy, H. L. Perlis, Florence C. Perry, Samuel C. Petix, George N. Petroff, Louisa I. Piccone, Ralph Piper,

Johannes D. Plekker, R. C. Pöchert, Harold M. Podolsky, Clement J. Pollina, John D. Pool, Andrew D. Potter, Marcia L. Potter, Robert F. Powers, Lawrence A. Pratt, Sanford Press, A. Hazen Price.

E. J. Quirk, Russell M. Ragan, J. A. Ramsey, Richard L. Rapport, Louis C. Ravin, George P. Raynale, Harold F. Raynor, Myron S. Reed, Adolph T. Rehn, William S. Reveno, Harold J. Rezanka, David Rich, C. J. Richards, Robert C. Ries, G. H. Rigterink, Frank Rizzo, Edward L. Robb, Herbert F. Robb, J. Milton Robb, George W. Rodkey, Aaron Z. Rogers, Albert Rome, Charles T. Root, Louis H. Rosenthal, Felix F. Rosenwach, E. M. Rotarius, George E. Roth, Arthur M. Rothman, Emil D. Rothman, Leon Rottenberg, A. Ashley Rousuck, Wilfred J. Rowell, Milton J. Rueger, Walter Z. Rundles.

A. L. Sagone, Rene J. St. Louis, Duncan Salot, Russell F. Salot, Irvin W. Sander, Nathaniel Sandler, M. Andrew Sapala, Leo B. Saraf, Lloyd L. Savage, Eugene M. Savignac, Donald Schiff, Harold K. Schillinger, Ray D. Schirack, Norman D. Schofield, William E. Schumacher, J. A. Schwartzberg, Bert Seligman, George Sewell, Maxwell L. Shadley, S. J. Shanoski, I. Allen Shapiro, C. H. Sharrer, Daniel H. Sheeran, W. L. Sherman, William L. Sherman, Jr., A. P. Shewchuk, Peter G. Shifrin, Herbert L. Shroyer, William B. Siegel, I. Z. Silvarman, Ezra I. Silver, I. Walter Silver, Minor D. Silberberg, Clarence E. Simpson, E. J. Singer, Harold Singer, Victor J. Slominski, Joseph Slusky, Fred R. Smith, J. Allen Smith, Maurice J. Smith, Edmund S. Socha, Morris B. Sofen, Morris L. Sorkin, Milton L. Sorock, Manuel Sota-Rivera, George H. Southwick, I. L. Spalding, Maurice J. Spector, Grant Gould Speer, James E. Spens, Earle W. Spohn, Carl J. Sprunk, John P. Sprunk, Myron R. Stanton, William J. Stapleton, Frederick B. Steiner, Louis J. Steiner, Wilbur J. Steininger, Leonard H. Stern, Lewis L. Stewart, Thaddeus Stokfisz, Sidney Stone, Robert M. Stow, Fred L. Strickroot, Donald F. Strohschein, Sam Sugar, Donel Sullivan, James J. Sullivan, E. C. Swanson, Robert G. Swanson.

F. W. Tamblyn, Helen Tasker, Nelson Taylor, Malcolm Tear, T. A. Tenaglia, Charles W. Thompson, Hugh O. Thompson, W. Kenneth Tregenza, H. L. Tremain, Raymond G. Tuck, Roy D. Tupper, Merald G. Turner. Clarence E. Umphrey, William K. Usher.

B. VanDerKolk, Leonard F. VanRaaphorst, Edward M. Vardon, Harold E. Veldman, Anton G. Venier, John VerMeulen.

Ralph Wadley, Ruth E. Wagner, Darwin Earl Wagoner, Roger V. Walker, Roger V. Walker, Jr., C. Harry Wallman, Arthur W. Walter, Clarence Walton, Max Warren, Wadsworth Warren, J. Edwin Watson, M. A. Wayne, Clarence E. Weaver, Harry B. Weaver, John E. Webster, Harold R. Weidner, C. Richard Weinberg, David Weingarden, Jack I. Weiss, Martha Wells, Jacob F. Wenzel, Inga Kirby Werness, John L. Wiant, Fred K. Wietersen, M. M. Wilde, Robert J. Williams, George W. Wilson, Walter J. Wilson, Jr., G. E. Winter, George R. Wiseman, Harry C. Wissman, J. E. Witters, Kenneth A. Wood, J. J. Woods, Jean Stevenson Wright, William C. Wyte.

I. V. Yale, Doris Parkinson Yankley, Robert R. Yanover, Morton Yarrows, Arthur J. W. Yates, Floyd Yeager, William J. Yott, Donald C. Young.

Michael N. Zelenock, H. B. Zemmer, Irwin H. Zielke, J. G. Zimmerman. Walter J. Zimmerman, Carl R. Zolliker, Henry J. Zukowski, E. J. Zyla.

Following are the names of the doctors of medicine, *not* alumni of the College of Medicine of Wayne University, who have contributed to the medical library fund, for which they receive credit from the AMEF:

Sidney L. Adelson, E. Bryce Alpern, Charles H. Altschuler.
James B. Blodgett, I. V. Botvinick.
Mario S. Cioffari, Harold E. Clark, Charles L. Clarke.
I. Donald Fagin, Samuel Glassman, E. S. Gurdjian, Charles G. Jennings, Charles G. Johnston.
George Kinsley.
David Leach, James E. Lofstrom.
Arthur B. McGraw.
V. S. Mancuso, Merle M. Musselman.
Max Karl Newman.
Walter R. Parker, Grover C. Penberthy.
James R. Rogin.
Carolyn Salisbury, Suzanne Sanderson, Geza Schinagel, Edward D. Spalding, Saul C. Stein, Walter A. Stryker, H. Saul Sugar.
Ivan B. Taylor, Robert C. Thumann, Vincent J. Turcotte.
J. K. Weston.

A list of Michigan doctors of medicine who contributed direct to the University of Michigan Medical School, for which they receive credit from the AMEF, will be published in a forthcoming number of JMSMS.

Kraurosis or leukoplakia may be associated with cancer of the vulva.

* * *

The best treatment for leukoplakia of the vulva is radical excision.

* * *

Primary cancer of the liver may originate from the parenchyma or the biliary system and many are secondary to cirrhosis.

* * *

The outstanding sign of primary liver cancer is progressive liver enlargement frequently accompanied by anemia, weakness, abdominal pain and gastrointestinal disturbances.

Federal Medicine

COMPULSORY HEALTH INSURANCE— AN ECONOMIC ISSUE

In a study reported in the February issue of the *Quarterly Journal of Economics,* Rita and W. Glenn Campbell suggest that money spent for better housing, sanitation and research in preventive medicine for low income groups would be a more economical method of raising the country's health level than by expending the same amount in drugs and physician's fees. The authors feel that families with incomes of less than $2,000 per year—less than the pre-Korean living level —probably cannot pay for their medical expenses. There are 9.6 million such families in the United States. However, some of these are farm families with non-money incomes, and others may be only temporarily at this income level. It is estimated, therefore, that 6 million of the 46 million families in the United States cannot afford medical expenses. The Campbells point out that charity cases will continue to be financed from general tax funds even under a compulsory health program.

IT'S STILL COMPULSORY

Oscar Ewing has finally admitted publicly that any government-sponsored health insurance plan would have to carry the compulsory feature.

Mr. Ewing made the admission in an informal interview with three CBS radio Washington correspondents on the CBS network show, "Capitol Cloakroom," from Washington on September 5. He was a guest on the program; the three correspondents were Griffing Bancroft, Bill Sydell and Ron Cochran.

The interview, as transcribed by Radio Reports, Inc., went like this:

COCHRAN: "Well, do you know how Governor Stevenson stands on the matter of compulsory health insurance?"

EWING: "I think he has some questions in his mind about it. I have not discussed it with him. The only thing that I know about his views was in one of the magazines recently where he said that he was not sure that this suggestion of ours was the best, that he rather —he looked with some favor on a plan that would take care—where the insurance would merely take care of catastrophic illnesses, that is probably that the patient would have to pay the first hundred or 150 or 300 dollars of the sickness and then the insurance would take care of the rest."

COCHRAN: "Like $50 deductible automobile insurance."

EWING: "Exactly."

COCHRAN: "If you get a fender bumped."

EWING: "And such thing is well worth considering."

BANCROFT: "Would it have a compulsory feature in it?"

EWING: "Oh, *you can't have it without the compulsory feature* to my way of thinking because that's the only way that you can get everybody in and get the insurance rates down to a low enough level so that it's a workable thing. Otherwise, all the people that are prone to sickness and the older people, they'll take the benefits of insurance and the young people and the healthy won't do it, and it's very much better to have it just as you do social security, your old age and survivors insurance. It's compulsory and you're building up a fund there during your working years that meets these expenses."

—*AMA Secretary's Letter.*

SUBVERSIVE CONNECTIONS CITED

The Washington State Medical Association held a most enthusiastic meeting in Seattle and, in addressing the doctors, Ernest B. Howard, M.D., Executive Secretary, AMA, said that one of the strongest forces behind the administration's campaign for compulsory, tax-supported health insurance is the Committee for the Nation's Health, which has its headquarters in New York.

"This group," he said, "is the chief propaganda agency for socialized medicine. It has some imposing names on its letterhead—Eleanor Roosevelt, Philip Murray, William Green and Robert Sherwood.

"But it should also be noted that out of 166 charter members, ninety-two have been cited one or more times because of subversive connections or activities by the House UnAmerican Activities Committee. Over half of the members serving as officers and directors since its organization in 1946 have subversive records and have long been associated with avowed Communists."

THE AMERICAN LEGION AND THE DOCTOR

The AMA Board of Trustees has reiterated its previous stand that doctors everywhere should take a more active interest in the affairs of the American Legion. Physicians who are members of the Legion were urged specifically to attend meetings of their posts, since the policies of the Legion, like those of the AMA, are decided at the grass roots level.

The Board's expression came after it had studied a report on health matters which were discussed at the Legion convention in New York a short time ago.

Legion delegates adopted a resolution opposing I.L.O. procedures that would socialize medicine by international treaty, and they turned down another resolution which would have mandated the Legion to urge the Veterans Administration to give special recognition to chiropractors. This would have permitted veterans to choose chiropractic treatment at government expense. A similar resolution for optometry was also defeated. The chiropractor resolution, coming from eight state departments of the Legion, resulted in one of the bitterest battles on the floor of the convention. The fact that

(Continued on Page 1414)

Meat...

and its Wide Clinical Applicability

That meat is an important component of the high protein diet[1] employed in the treatment of many pathologic states is evident from the following dietary suggestions that have been recommended by some authorities in the field of nutrition:

Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

1. Lewis, H. B.: Proteins in Nutrition, in Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 1.
2. Patek, A. J., Jr.: Evaluation of Dietary Factors in Treatment of Laennec's Cirrhosis of Liver, J. Mt. Sinai Hosp. *14:*1 (May-June) 1947.
3. Portis, S. A., and Weinberg, S.: Recent Advances in the Medical Treatment of Cirrhosis of the Liver, J.A.M.A. *149:*1265 (Aug. 2) 1952.
4. Welch, C. S.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16:*161 (Jan.) 1937.
5. (a) Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 89.
   (b) Ibid., p. 133.
6. Mosenthal, H. O.: Management of Diabetes Mellitus, An Analysis of Present-Day Methods of Treatment, Ann. Int. Med. *29:*79 (July) 1948.
7. McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 5, Philadelphia, W. B. Saunders Company, 1949, p. 364.
8. Morrison, L. M.: Arteriosclerosis: Recent Advances in the Dietary and Medical Treatment, J.A.M.A. *145:*1232 (Apr. 21) 1951.
9. Low Blood Sugar Level; Queries and Minor Notes, J.A.M.A. *149:*1358 (Aug. 2) 1952.
10. Goodman, J. I., and Garvin, R. O.: Results of High Calorie Feeding, Gastroenterology *6:*537 (June) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

Main Office, Chicago...Members Throughout the United States

Editorial Comment

THE PRESIDENT'S POLITICAL CHESTNUT

The President trotted out another of his political chestnuts Tuesday when, addressing a convention of hospital administrators, he revived his socialistic pet scheme. He called it "a goal of enterprise—American enterprise." Which, fortunately, it is not.

In an off-the-cuff remark, Mr. Truman recalled the furor which the medical profession raised when Mrs. Millard Fillmore installed the first bathtub in the White House about 1850. The reactionary doctors wanted to lynch the good lady, he declared.

In a recent issue of the *Saturday Evening Post*, Beverly Smith exploded the Fillmore bathtub legend. He proved that the story was concocted out of whole cloth by Henry L. Mencken in one of the latter's whimsical moments during World War I. Soon after, Mencken confessed his hoax.

Smith, after careful research, learned that the first bathtub was installed in the White House by Truman's idol, Andy Jackson, somewhere between 1829 and 1833.

But here again, the truth is a minor detail to Andy's successor. He sticks by the Fillmore story as proof of how reactionary the medical profession is. After all, it opposes socialized medicine.

"And now," said Harry, just to make monkeys of the medical fuddyduddies, "there are more bathtubs in the White House than in the Benjamin Franklin Hotel."

The management of that hostelry explained they had one in every room—1,200 to be exact.

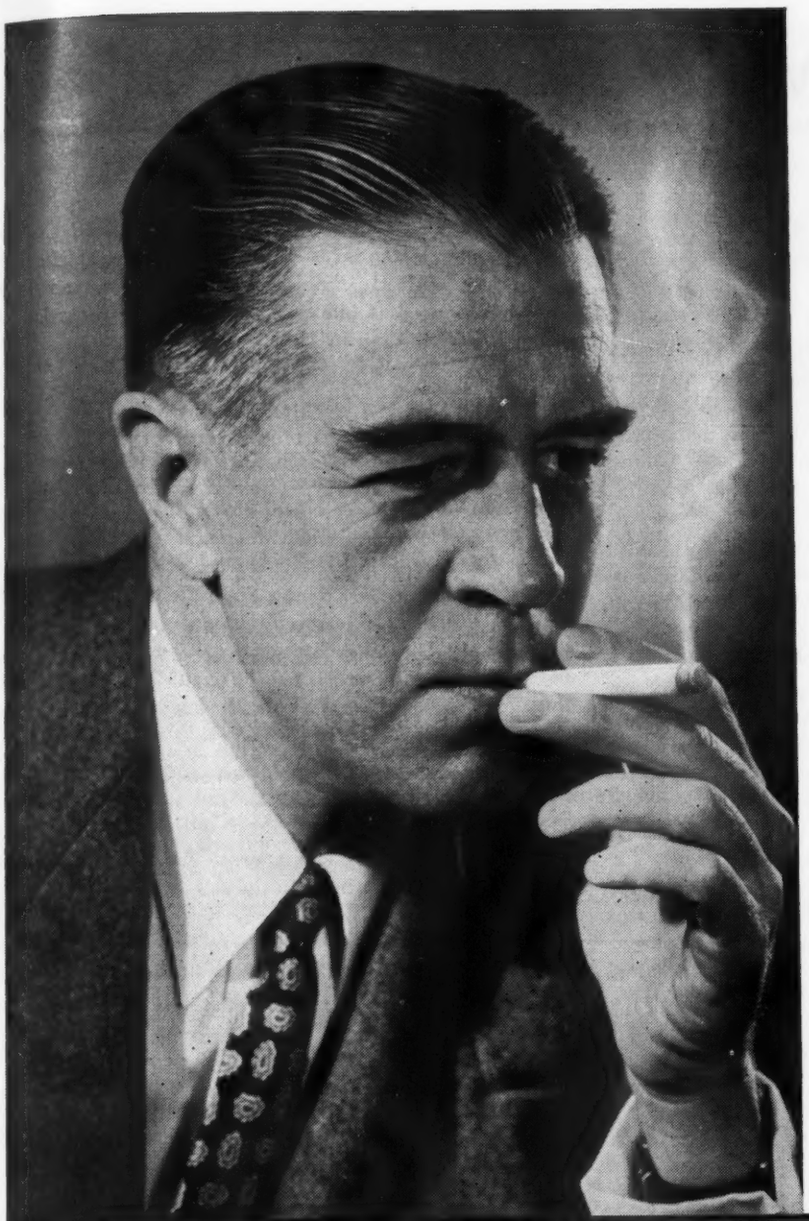
If the White House has that many, one wonders why it wasn't easier for Harry to clean up his Administration.—Editorial, *Detroit Free Press*, Sept. 18, 1952.

PRIVATE PATIENTS

UMS will not compromise its position upon two issues. Hospitals will not be paid to practice medicine. Nor will payments be made for student surgery.

The "Schedule of Allowance" equals or betters the minimum fee schedule of Workmen's Compensation law. It provides full settlement of the patient's bill when the Subscriber member's income is within certain specified limits. Most physicians readily agree that our members are entitled to no less consideration.

Payments to student doctors would be unfair to both patients and doctors engaged in private practice. The resources of UMS will not be diverted to the support of hospitals or medical education. The true interests of our public will be served best by such policy.—*United Medical Service Bulletin* (New York).



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and <u>any</u> other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.

2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and <u>any</u> other leading brand.

PHILIP MORRIS

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

Military Medicine

PERMANENT RUSK COMMITTEE PROPOSED

The Health Resources Advisory Committee (Rusk Committee) has recommended that it (or a similar group), be continued on a permanent basis. Its summary report says: "It has become increasingly apparent . . . that some mechanism similar to the Committee should be continued not only during this period of mobilization but as a permanent statute of the federal government. The Committee believes it is vital that . . . at a sufficiently high organizational level to make its work effective, there must be a co-ordinating body in the health fields if full utilization for both civilian and military needs is to be made of the health potentials of our nation."

The Committee, organized in 1950, now has three roles, (1) advising Office of Defense Mobilization on all health matters, (2) functioning as the National Advisory Committee to Selective Service, and (3) advising Defense Department on call up of medical reserves by balancing civilian against military needs for physicians and other personnel in the health fields.

The Committee commended the Armed Services for providing the best military medical care in history, while at the same time reducing the physician ratio from the World War II peak of six per 1,000 troops to the current 3.7. This means, the Committee explains, that 5,000 physicians who might be in military service have remained in civilian practice. The Defense Department saving resulting from the lower ratio was estimated at 40-50 million dollars.

SELECTIVE SERVICE

Selective Service's National Advisory Committee is appealing to hospital administrators for help in urging recently-graduated physicians to register under the doctor-draft law. "The only exception," the notice says, "is for those who must complete their internship before receiving their degree and during such internship apply for and accept a commission in the armed forces."

ONCE-DEFERRED 4F'S NOW IN SERVICE

The lowered mental standard for military induction, ordered by Congress, is bringing results. Already 17,000 men once classified 4-F for mental reasons are in uniform and approximately the same number are awaiting induction. Of the 114,000 re-examined so far, 33,000 or slightly less than one third have been found mentally fit for service. Still to be re-examined are 186,000. Congress in June, 1951, directed that the percentile score in the Armed Forces Qualification Test (mental) be lowered from 13 to 10. Re-examinations began the first of this year and are now running at the rate of about 25,000 a month. Congress also ordered that the same physical standards effective in 1945, at the close of World War II, should prevail. The armed forces say, however, that since 1948 physical standards have been no higher than in 1945.

CASUALTIES HANDLED BY NAVAL HOSPITAL SHIPS

For the first twenty-one months of the Korean War, admissions to the three Naval Hospital Ships operating in the theater averaged more than fifty per day, with a peak of almost 100 per day during the hard fighting of late 1950 and 1951. These and other statistics on the three hospital ships—*Consolation, Repose* and *Haven*—were released by the Statistical Division of the Bureau of Medicine and Surgery. Through last March, more than 33,000 casualties were handled by the three ships.—*AMA Capitol Clinic*

"FRINGE BENEFITS"

The United States Chamber of Commerce estimated Saturday that American businesses pay their employes nearly $25,000,000,000 a year in "hidden pay-roll" benefits.

The money goes to the workers under a great variety of programs including pension plans, sickness and death benefits, holidays and Social Security and unemployment insurance payments, the Chamber said.

It based its estimate on a nation-wide survey of 736 companies conducted by Dr. Emerson P. Schmidt, the organization's director of economic research. He said these companies paid out an average of $644 per employe last year in "fringe benefits."

This, he said, was an "all-time high" average cost to the companies.

Schmidt said 138 of the companies were included in two similar surveys by the Chamber. Their "hidden payroll" costs jumped in four years from an average of $410 a year per employe to $681—or 66 per cent—he asserted.—*Detroit Free Press,* Sept. 14, 1952.

THE AMERICAN LEGION AND THE DOCTOR

(Continued from Page 1410)

it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 51 NOVEMBER, 1952 NUMBER 11

Beaumont and St. Martin

By Stuart V. Smith
Vice President, Wyeth, Incorporated
Philadelphia, Pennsylvania

IT IS fitting, indeed, that we gather in this room tonight to honor the memory of a great man and doctor. Within a few miles of this place, on the Island of Mackinac, in 1822, a medical pioneer made history which has affected the lives of people the world over. Few people, however, know this doctor's name, and fewer still know the significance of his work.

William Beaumont, M.D., is well known to you. His great work, which gave medicine its first reliable information on digestion, has been heralded for decades by the profession, but it has passed almost unnoticed by the people who have reaped the benefits of his study.

Wyeth, who has long been concerned with this problem, undertook a project in 1939 designed to acquaint Americans with their fellow countrymen—physicians and pharmacists who have contributed greatly to the advancement of medicine from which society has benefited.

To accomplish this purpose, a series of original canvases entitled "Pioneers of American Medicine" was conceived. The outstanding American illustrator and muralist, Dean Cornwell, N.A., was commissioned to execute the paintings. Months of painstaking research insured the accuracy of detail that went into each painting.

I recall Dean Cornwell telling me of his experience in gathering background for the canvas that he painted of Major Walter Reed. He spent many weeks in Havana taking photographs and making piles of sketches of furniture and wall details because accuracy is so important. He told me that in order to get sketches of the kind of furniture that likely surrounded Dr. Finlay on the day he received Major Reed he had to visit many of the wealthy homes in Cuba.

"It was a charmng experience," he related, "but also hard work—harder than the kind a door-to-door canvasser does. People don't seem to get used to the idea that an artist works, so each call became a visit with accompanying cocktails. That meant by the time the day had worn on that I had had quite a few. That kind of work takes a lot out of a man."

Well, the canvases were completed and they fulfilled our every wish. They have been and are a great tribute to the doctors who have made such tremendous contributions to American medicine. They have been exhibited throughout the United States and have been seen by thousands of school children and adults alike.

It is my personal opinion that the painting of Beaumont and St. Martin is among Cornwell's greatest. The detail and accuracy; the color and expressions have created a living image in my mind. I hope that you, too, will share this memorable experience when you view the dramatic scene which the artist has recreated.

Major William Beaumont well deserves a prominent place in the history of physiology. His protracted and careful experiments on the French Canadian, Alexis St. Martin, formed the basis of his masterpiece, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion." It is a classic report on the numerous experiments he performed.

I am sure that you all will recall the story which gave birth to this great work. It was in 1822 on Mackinac Island when St. Martin

Remarks delivered on the occasion of the presentation of the "Beaumont and St. Martin" painting to the Michigan State Medical Society, Tuesday, September 23, 1952.

suffered a gunshot wound. Although he recovered, the wound, which perforated to his stomach, failed to heal, making necessary the wearing of a compress over the permanent gastric fistula. He became known as the "man with a lid on his stomach."

Imbued with true scientific spirit, Beaumont, then the army surgeon assigned to Fort Mackinac, accurately recorded the movements of St. Martin's stomach during digestion, and studied the secretion of the gastric juices and the effects of hunger, anger and other emotions on digestion.

I would like to pay special tribute to those of you in this Society who have worked ceaselessly in behalf of your Beaumont Memorial Restoration Fund. When reconstruction of the old American Fur Company Store on Mackinac Island is completed, it will become a medical shrine. It will be a constant reminder to the thousands of annual visitors to the Island of the profession's continued efforts to advance the science of medicine. Wyeth is particularly proud that this painting of Beaumont and St. Martin will hang in the restored fur company store as a perpetual reminder of Michigan's part in significant and inspiring medical pioneering.

Ladies and gentlemen, it is with great personal pleasure and pride that I, in behalf of Wyeth, Incorporated, present to Dr. Otto O. Beck, as president of the Michigan State Medical Society, and as chairman of the Beaumont Memorial Restoration Fund, this canvas of Beaumont and St. Martin from among the Wyeth collection of "Pioneers of American Medicine."

MSMS

The solution to the problem of specific anticancer therapy awaits a better understanding not only of the metabolism of cancer cells but of the mechanism of normal growth as well.

* * *

The development of improved methods of cancer therapy seems certain. In the meantime, over-optimism concerning new remedies must be guarded against assiduously. Every effort must be made on the part of scientists, science writers, and pharmaceutical manufacturers to prevent the release to the lay press of over-enthusiastic news stories of new "wonder drugs" or therapeutic procedures. The false hopes raised by such stories have caused patients to postpone urgent surgery or to refuse irradiation until their lesions have advanced beyond all hope of control. Persons in high government office and other responsible positions also have an obligation to the public to refrain from promoting new and inadequately tested measures. Such misguided activity can result in incalculable harm to the health of the public.

The Value of the Beaumont Memorial to the Medical Profession of Michigan

Harvey M. Merker, Sc.D.
Detroit, Michigan

SINCE Dr. William Beaumont was the first medical man to suspect that there was some other active agent (now known as pepsin) in the stomach besides free hydrochloric acid, I feel it a great honor to be requested to make a few remarks in connection with the Beaumont Memorial. My first assignment at Parke, Davis & Company in 1909, was to develop a new process for the manufacture of pepsin, consequently it has been a real thrill to be connected with this Beaumont project.

When a doctor enters the room, a thousand men appear. He is a composite of—

Jenner—discovered smallpox vaccine
Harvey—discovered the circulation of the blood
Morton—gave the first public demonstration of ether anesthesia
Lister—used first antiseptic in the form of crude carbolic acid
Pasteur—established the fact that germs cause disease. —introduced pasteurization, sterilization, immunization and vaccination against rabies.
Robert Koch—isolated tuberculosis bacillus
Von Behring—produced the first antiserum in the form of diphtheria antitoxin
Roentgen—discovered x-rays
Curies—gave us radium
Walter Reed—proved that the Stegomyia mosquito was the carrier of yellow fever infection
General Gorgas—a great sanitarian, whose methods of sanitation made possible the building of the Panama Canal
Paul Ehrlich—the founder of chemo-therapeutics
Fred Banting—discovered insulin
Alexander Fleming—discovered penicillin, opening up the field of antibiotics

Is it any wonder that James Bryce, the famous English statesman and historian, made the following remark: "Medicine is the only science that labors to destroy itself?"

Address at the Beaumont Breakfast, Michigan State Medical Society Session, Detroit, September 25, 1952.
Dr. Merker is Director of Inventory Control and Chemical and Pharmaceutical Consultant, Parke, Davis & Company, Detroit.

You will note that in the previous list, the name of Dr. William Beaumont is absent. Because of the significance of his fundamental, physiological research, his name should be added. Beaumont's experiments are notable because:

1. They formed the basis of subsequent work on gastric digestion.
2. They shed new light on the nature of the gastric juice and the process of digestion in the stomach.
3. They represented the first study of digestion *in situ*.
4. They were one of the most romantic episodes in the history of medicine.
5. They were carried out in the backwoods of America by a much harassed Army Surgeon with no other laboratory than the gunshot-wounded body of a half-breed Indian, Alexis St. Martin, a human laboratory.
6. They were a milestone on the road to Pavlov's experiments.
7. They are a landmark of American Medical literature.
8. Beaumont was the true leader and pioneer of experimental physiology in the United States.
9. Every physician who prescribes for digestive disorders and every patient who is benefited owes gratitude to Beaumont.

Gentlemen, we have a marvelous opportunity to identify Michigan Medicine with Michigan. The Beaumont Memorial is a beacon to remind the public that medical progress is rooted in the history of this state. The Michigan doctor is privileged to honor this heritage.

Parke, Davis & Company is proud to have had a real part in the introduction of this memorial, having furnished funds for purchasing the original fur-trading post and land.

Medicine has the opportunity of identifying itself with the Beaumont Memorial and we should grasp it in convincing fashion.

Gentlemen, let us make the most of this opportunity, and in doing so, we will honor the medical profession, the people of Michigan, the state of Michigan, and give the Beaumont Memorial the place it deserves among the medical shrines of the world.

MSMS

YOUR SHARE

If everybody in the country were to contribute an equal amount to cover federal spending in 1952, the sum would be $548.38. In 1940, per capita federal expenditures totaled $68.16, while way back in 1900 they added up to only $6.85.

Case of Candida Asthma and Its Management

By O. Neufeld, M.D., and
W. L. Wallbank, M.D.
Toledo, Ohio

THE TERM Candida has been agreed upon by the Third International Microbiological Congress in 1939 to replace the familiar Moniliasis. Candida albicans is potentially pathogenic and may produce lesions in the mouth, vagina, skin, nail, bronchi, lungs and occasionally meningitis. This organism is pathogenic at all ages, in both sexes and in all races.

A case is being presented where candida albicans provoked and caused asthmatic manifestation of hypersensitivity, and the bronchial infection and asthmatic symptoms were probably cured by the persistent use of an aerosol of sodium caprylate.

It has been demonstrated previously that the sodium salt of caprylic acid inhibits, *in vitro,* the growth of Candida albicans (1), (2), and also that sodium caprylate, applied locally, has been effective in the treatment of cutaneous infection due to this organism (3). Due to the popularity of aerosols as a means of introducing chemical agents into the respiratory tract, sodium caprylate aerosol was prepared and proved to be effective in the treatment of an infection due to Candida albicans.

The patient, A.S.P., a white man, born in 1893 in Michigan, gives a history of bronchitis at the age of seven and persistent attacks of asthma since the age of eight. The patient does not remember any childhood diseases. There is no history of asthma in the family and no family history of allergy. The attacks of asthma, which began at the age of eight, were of different duration—from thirty minutes to two hours. At that time, the patient did not have any medication for relief and had to remain in a standing or sitting position until the attack of asthma disappeared. In 1926, he suffered with infection of the sinuses and a few polyps were removed. He did not, however, notice any improvement following this. Since 1931 he started using adrenaline quite frequently. In 1935, because of pyorrhea, upon advice of his dentist he had all his teeth extracted, which supposedly would influence his respiratory suffering. Skin tests were never done and an allergist was never consulted. In January, 1950, he was admitted to Crile Hospital in Cleveland for hemorrhoidectomy. At that time a routine chest x-ray was taken and sputum examined for acid-

fast bacilli which was positive on culture. Because of these findings he was admitted to the Wm. W. Roche Hospital February 1, 1951, where sputum has been found positive for tubercle bacilli.

X-ray Findings: Right—very soft irregular exudative infiltration scattered throughout the major portion of this lung with a thick-walled, well-outlined cavity at the level of the second rib anteriorly. Left—soft exudative infiltration from the apex to the fifth interspace anteriorly, most marked in the perihilar region, but no definite cavity could be found. Diagnosis: pulmonary tuberculosis, far advanced, bilateral, active, severe bronchial asthma.

Physical examination was essentially negative except for coarse râles and wheezing on inspiration and expiration over the entire chest and some moderate limitation of motion in the left ankle joint which resulted from an accident at the age of fourteen.

Blood—Hemoglobin 13.2, RBC 3.09, leukocytes 6.100, neutrocytes 79, lymphocytes 15, monocytes 6. Sed. rate 79 mm. (Westergreen). Urine—specific gravity 1012, no albumen, no sugar, a few leukocytes in the sediment.

FBS—110 mgm. EKG—normal. Blood cholesterol—240 mg. Cephalin cholesterol flocculation test—negative in twenty-four and forty-eight hours. PSP—over 60 per cent two hours.

Because of the positive sputum and x-ray findings, the patient was started on Streptomycin gram one daily combined with pneumoperitoneum. The soft scattered lesions throughout both lung fields did not respond very dramatically to Streptomycin and, as far as his asthma is concerned, he continued to suffer with very severe attacks almost every night. These were relieved with adrenaline.

Sputum collected very carefully to avoid contamination was cultured on Saboraud's dextrose agar. After five days, creamy moist colonies developed in all tubes which displayed the cultural characteristics of Candida albicans. The unstained sputum contained many hyphae and yeast cells which were Gram positive. Cultures were repeated with the same results. Staphylococcus aureus and alpha hemolytic streptococcus were cultured from the sputa on bacteriologic media.

In spite of the positive findings on culture examination, the possibility that Candida albicans may represent a common association in pulmonary tuberculosis was not excluded until the patient responded to specific therapy and repeated examination of sputum for Candida albicans following treatment was negative.

Treatment.—All drugs previously taken for relief of asthma as well as streptomycin were discontinued and a 10 per cent solution of sodium caprylate in propylene glycol was prepared and administered every three hours. Totally, he received one to two grams of sodium caprylate every twenty-four hours by inhalation. This therapy was continued for a period of four weeks. The patient became essentially free of asthma and at the time of this writing, four months after completion of the therapy, the patient has remained essentially free of asthmatic manifestation during the entire period.

Sputum cultures on Saboraud's medium showed no growth of Candida albicans on a number of occasions, and a drop in eosinophil count from 34 to 17 was noted. On physical examination, he has musical râles over the left chest posteriorly.

His pulmonary tuberculous lesions were not influenced at all by the sodium caprylate inhalation.

Bibliography

1. Keeney: Medical mycology. M. Clinics North America, pp. 323-342 (March) 1945.
2. Keeney: Sodium caprylate, a new and effective treatment for moniliasis of the skin and mucous membranes. Bull., Johns Hopkins Hosp., 75:33, 1946.
3. Keeney, Ajilla, and Langford: Studies on common pathogenic fungi and on actinomyces boves; in vitro effect of fatty acids. Bull., Johns Hopkins Hosp., 75:377, 1944.

MSMS

CHARITY IS NOT MASS PRODUCED

Worthy desire sometimes cloaks unworthy principle. This may be happening in the present tendency to federate fund raising for charity. Nothing could be more worthy than charity. To give to others is the ultimate proof of civilization and maturity. But when charity takes on the aspects of mass production and dictatorial direction it becomes something other than charity. Hidden beneath the golden cloak of charity is the leaden foot of authoritarianism.

The very word *charity* implies something to which the principles of big business can never apply. It is derived from the Latin *caritas* meaning dearness or love. First definition in Webster is, "Christian love." This is followed closely by, "Divine love for man—act of loving all men as brothers because they are the sons of God." Thus true charity is an expression of warm human interest in the lives of others. It is an overflow from the deep well of kindliness within and carries with it the gift of money or goods. The word *charity* does not seem to fit very well when the giver, just to avoid embarrassment, parts with a sum of money, neither the amount of which nor destination of which is determined by himself.

The person who gives charitably should be free to choose the individuals or groups to whom he is to give. He should know who is to receive his money and how it is to be used. He should be convinced that the need is great and the expenditure is sound. Such individual freedom and individual responsibility is largely lost in federated giving. Amounts to be raised are determined not by the interest of the giver but by a board of experts. They, impersonally and with great impartiality, direct an affair which should be intensely personal and decidedly partial. No man should tell another whom he should love.

Charity is one of the divine attributes of mankind. Like Portia's quality of mercy it blesses both the giver and the receiver. There should be no restraint of charity. It should come freely from the heart for it is truly the result of individual generosity. It is not subject to mass production.—*Northwest Medicine,* September, 1952.

Recent Advances in the Diagnosis of Heart Disease

By Raymond D. Pruitt, M.D.
Rochester, Minnesota

I SHOULD LIKE to begin this discussion with an obvious comment upon the smugness evinced by its title. We say we are going to talk about recent advances in the diagnosis of heart disease when actually we have neither the wisdom nor the vantage point of time to judge whether the matters of which we speak are advances or regressions. When we shear away the scientific trappings, we recognize that these things which today we are doing differently from the manner in which they were done ten years ago have no unique qualities other than complexity and strangeness. Another ten years may find us reverting to the simpler methods presently discarded.

The Electrocardiogram

It would be a reasonable estimate, I believe, that fully one third of the articles in each issue of the two leading American journals of the heart and circulation are concerned with electrocardiography. I believe it would be equally reasonable to state that in so far as the care of the patient is concerned, there has been no publication of major significance since the article by Wilson and his associates on the precordial electrocardiogram in 1944.[5] Some interesting observations have been reported subsequently, a few of which we shall consider presently. But there is basis for wondering whether the continuing efforts at refinement in this particular field are justified.

There has been change, however, in the application of electrocardiography to the care of the patient. This change is the immediate consequence of dissemination of knowledge concerning those fundamental studies made and reported prior to 1944. It is becoming increasingly uncommon to see an electrocardiogram inadequate with respect to the number and type of leads. Interpretations generally speaking are becoming more exact and less speculative. "Coronary sclerosis" as a diagnosis apart from myocardial infarction or ischemia is being discarded as a proper electrocardiographic deduction. These changes truly are advances of a kind and at a level of greatest significance in the care of the patient with cardiac disease.

But as the physician has come to recognize the limitation of the routine electrocardiogram in the diagnosis of coronary sclerosis unattended by myocardial changes, he has sought other ways of identifying the presence of clinically significant sclerosis. The recording of electrocardiograms on patients subjected to some circumstance which places the heart under stress now has been carried on for a period sufficient to permit reasonably mature judgment on the usefulness of such procedures. The observations of my colleagues and myself would lead us to propose:

1. That the method of imposing the stress is not an issue of major importance in determining whether or not useful information is derived from the procedure. Either exercise or exposure to oxygen deprivation can be carried to a point of producing stress with comparable results.
2. That irrespective of the method used, the relationship between the degree of coronary sclerosis in the patient and the degree of abnormality appearing in the electrocardiogram during the test will remain frustratingly variable. We have observed two patients, one of whom exhibited marked electrocardiographic changes when subjected to oxygen deprivation and another who did not. Both died within a few months following the test and at necropsy were observed to have hearts of similar size and coronary sclerosis of equal degree.
3. That because approximately 25 per cent of patients whose coronary arteries are sclerosed to a clinically significant degree do not develop electrocardiographic changes of consequence when exercising or subjected to oxygen deprivation, neither of these procedures can be relied upon as a means for excluding the presence of coronary sclerosis. Since there is little joy to be had in proving that a patient has coronary sclerosis and since this is the only reliable contribution which can be derived from exercise and hypoxia tests, we as clinicians await the development of an effective means of ruling out rather than ruling in the disease.

From the Division of Medicine, Mayo Clinic, Rochester, Minn.

Presented at the Eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, Michigan, September 28, 1951.

The esophageal electrocardiogram has been studied carefully by a number of observers in recent years. In our own experience its usefulness has been primarily in making more evident in certain instances the pathologic character of changes identified already in standard limb leads II and III and extremity lead aVF. We have found this technic helpful also in localizing more precisely the area of myocardium to which excitation is delayed in cases in which an increased width of QRS complex develops in the wake of an infarction.[1] In illustration of this function the following case is presented.

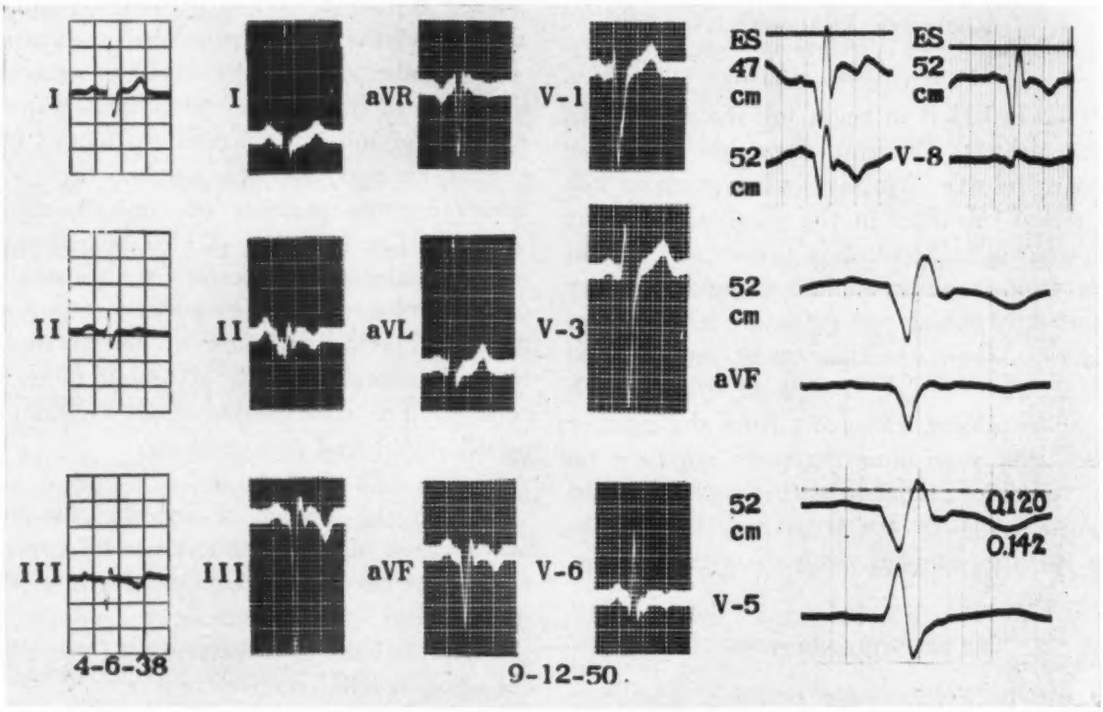


Fig. 1. Electrocardiograms in Case 1. The two sets of records in the lower right hand corner of the figure were made at triple the usual camera speed. "ES 47 cm" indicates an esophageal lead made with the electrode approximately 47 cm. from the dental margin. For additional details, see text.

Case 1.—A man, fifty-four years old, registered at the Mayo Clinic in September, 1950. He stated that in 1948 he had suffered an attack of pain in his chest which persisted for three days. The attending physician concluded that the patient had experienced a myocardial infarction. The patient spent seventeen weeks in bed, returning to light work thereafter. He experienced pain in the precordial region with effort.

When he was examined at the clinic, his blood pressure was 170 mm. of mercury systolic and 108 mm. diastolic. His weight was 216 pounds. The roentgenogram of the chest showed moderate cardiac enlargement.

In the electrocardiograms (Fig. 1) are found changes indicative of previous posterior myocardial infarction. The duration of the QRS complex is between 0.12 and 0.14 second as determined in the conventional leads, yet the form of these complexes is not consistent either with right or with left bundle-branch block. In the esophageal electrocardiograms recorded with the electrode at a level 52 cm. from the dental margin (Fig. 1, ES 52 cm.), the "intrinsicoid" deflection occurred 0.12 second after the onset of the QRS complex, the total duration of which was 0.142 second. These findings indicate late excitation of that portion of the heart underlying the esophageal electrode, namely, the posterior aspect of the base of the left ventricle.

The increased duration of the QRS interval is related here not to bundle-branch block, but to a peculiarly slow spread of excitation, probably over aberrant pathways, into the posterobasal portion of the left ventricle. This phenomenon develops in the wake of myocardial infarction and is variously termed arborization, postinfarction[1] and periinfarction block.[2]

If consistency is to be maintained with those statements which introduced this discussion of electrocardiography, then it must be observed that the identification of postinfarction block is just that sort of refinement accounts of which fill the pages of journals on heart disease, intrigue the students of electrocardiography, produce despair in the minds of busy practitioners, and add little or nothing to the care of the individual patient.

Let us hope, however, that even these minutiae may contribute to that steady evolution of electrocardiography from an empiric study to a mathematically precise science, and may aid in solving the intriguing problem of how the excitation process spreads through the myocardium.

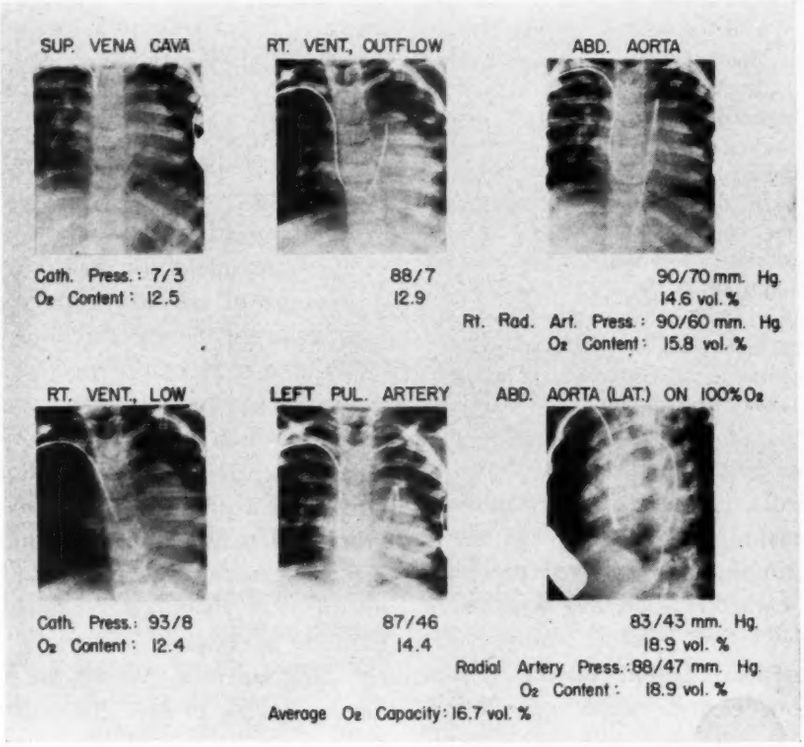


Fig. 2. Findings at the time of ventricular catheterization in Case 2. "Cath. Press." indicates the pressure in millimeters of mercury as obtained at the point where the tip of the catheter lay at the time the accompanying roentgenogram was made. "O_2 Content" refers to the number of cubic centimeters of oxygen contained in 100 cc. of blood.

Ventricular Catheterization Studies

The popularity of electrocardiography as a diagnostic technic must be derived in part from the totally innocuous and altogether pleasant nature of the procedure from the standpoint of both physician and patient. That one can acquire valuable data pertaining to the state of the myocardium without so much as breaking the integrity of the patient's skin is indeed a remarkable business.

By contrast, ventricular catheterization is the devil's own game. But like many other diabolic devices, this one is exceedingly clever and its institution has opened for its students a whole new field replete with quantitative data so dear to the scientific mind. Because most of the reports concerning catheterization studies have been laden with detail or concerned with innovations for getting more detail, the basic simplicity of the technic sometimes has been obscured. The information derived from catheterization of the right ventricle and related vascular channels is of three kinds. These are: (1) pressure levels in these chambers, (2) oxyhemoglobin saturation at various points along the way and (3) the presence of abnormal communications as evidenced by varients in the course taken by the catheter during the probing process. It is from analysis of evidence derived from these three categories that the majority of diagnoses have been ascertained.

In illustration of these points, consideration will be given to the following case.

Case 2.—The patient was a boy, four years of age. Examination revealed physical findings which were suggestive of pulmonary hypertension and indicative of a moderate degree of cardiac enlargement. A systolic murmur of moderate intensity was heard most distinctly in the second and third interspaces on the left side of the sternum with transmission toward the left clavicle and the back. In the roentgenogram of the chest the pulmonary vascular shadows were markedly increased. The electrocardiogram was interpreted as being compatible with hypertrophy of both ventricles. The clin-

ical picture was regarded as being most suggestive of a defect either in the atrial or in the ventricular septum, but the possibility of a patent ductus arteriosus was held to be sufficiently good and the patient's condition sufficiently critical that ventricular catheterization was undertaken even though the child's age necessitated that this procedure be done with the patient anesthetized.

The findings at the time of the catheterization are summarized in Figure 2. The pressure readings confirmed the clinical impression that pulmonary hypertension existed. The values for the oxygen content of the several samples of blood revealed definite "arterialization" of the specimen drawn from the pulmonary artery. And finally the course taken by the catheter indicated a communication between the pulmonary trunk and the descending limb of the aortic arch. Hence the diagnosis of patency of the ductus arteriosus associated with pulmonary hypertension was made. At the time of surgical exploration this diagnosis was confirmed and the ductus was ligated.

In what type of diagnostic problems has the procedure of ventricular catheterization established its greatest usefulness?

The answer is a simple one: In those problems in which study by catheterization has disclosed a surgically amenable lesion. Chief among such lesions are (1) atypical patent ductus (when typical, the diagnosis can be made on clinical grounds alone), (2) pulmonary valvular stenosis without ventricular septal defect, (3) mitral stenosis and (4) tetralogy of Fallot.

With the exception of mitral stenosis these conditions are relatively rare. The problem of mitral stenosis on the other hand sooner or later will present itself to every physician engaged in the practice of medicine. The results of ventricular catheterization are useful in three respects:

1. In excluding the presence of shunts. Only in exceptional instances does the diagnosis of mitral stenosis rest heavily on the results of catheterization studies. Instances are encountered in which the distinction between mitral stenosis and interatrial septal defect cannot be made with certainty unless catheterization studies are performed.

2. In establishing the presence of certain abnormal states characteristic of severe mitral stenosis, namely, pulmonary hypertension and a low, relatively fixed cardiac output.

3. In providing a means for studying objectively the results of attempts to relieve by surgical methods the obstruction imposed by the stenotic valve. In some instances in which a mitral commissurotomy has been done, we have observed a significant drop in the pressure within the pulmonary artery and a rise in the cardiac output particularly with mild exercise. On the other hand certain patients have had no appreciable improvement in these abnormal states. I should like to emphasize, however, that it is from a study of the facts in relation to patients that a sound position regarding mitral commissurotomy and related procedures will develop, and not from a study of the patients' subjective reactions alone.

One interesting corollary to the development of surgical treatment for mitral stenosis has been a sharpening of our discernment regarding certain features in the clinical diagnosis of the disease. We have come to recognize more clearly the rather remarkable variation in the nature of auscultatory findings which may occur from time to time in some patients. This recognition is the direct outgrowth of a plan whereby several consultants appraise a patient's problem within a brief time during the preoperative period. One may make an unequivocal diagnosis of mitral stenosis on the basis of a characteristic early and mid diastolic rumbling murmur. Within the hour, a second consultant, failing to hear the murmur, may question the diagnosis, recalls the first consultant, who, upon re-examining the patient, notes a definite change in the auscultatory findings with disappearance of the pathognomonic murmur.

We have thought again about the relationship between mitral stenosis and mitral regurgitation and are strongly inclined to the view that the existence of marked mitral regurgitation in the presence of an advanced stenosis is indeed uncommon. Hence when evidence can be assembled sufficient to make relatively certain a diagnosis of severe mitral stenosis, concern over coexisting regurgitation need not be serious even though a definite systolic murmur can be heard at the mitral area. The characteristics most helpful in recognizing the existence of severe stenosis are:

1. A typical rumbling diastolic murmur best heard at a point overlying the cardiac apex. This murmur occurs in coincidence with the phase of most rapid ventricular filling which takes place in mid and late diastole when the auricle is contracting rhythmically and in early and mid diastole when auricular fibrillation is present.

2. Pulmonary hypertension is evidenced in an accentuated second pulmonic heart sound, a

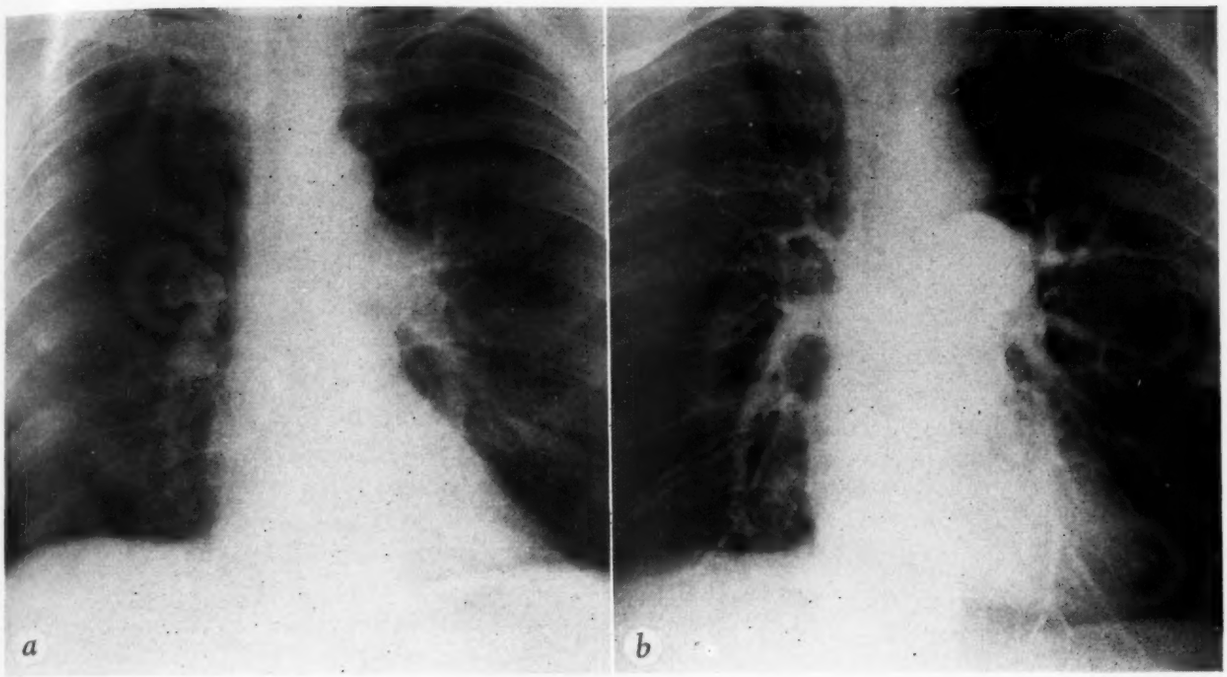


Fig. 3. Case 3. *(a)* Roentgenogram of the chest. *(b)* Angiocardiogram.

Graham Steell murmur and, in roentgenographic and fluoroscopic studies, dilatation of that portion of the cardiac shadow formed by the pulmonary artery. Precise measurement of the degree of hypertension is, as noted already, a valuable function of studies made at the time of catheterizing the right ventricle and pulmonary artery.

3. Right ventricular hypertrophy as evidenced by roentgenographic studies and by electrocardiographic findings.

On these clinical observations combined with careful appraisal of the historical data, the major steps can be taken in the selection of patients for mitral commissurotomy.

Angiocardiography

With respect to the technics of angiocardiography, I would make no pretext of competency. We are all familiar with the basic problems of the method which are (1) to get a sufficiently high concentration of dye in one or more chambers of the heart or in some portion of the great vessels to visualize adequately the structure under examination and (2) to secure roentgenograms precisely at those moments when visualization of chambers is most satisfactory.

The actual field of usefulness for the method has much in common with that of ventricular catheterization. Because catheterization can be done at a more leisurely pace, and because it provides information regarding pressure relationships and oxyhemoglobin saturations within the chambers of the right side of the heart and pulmonary arteries, this method has taken precedence in our hands over angiocardiographic study. However, in certain instances, the latter method is quite adequate and readily accomplished. This is particularly true when the problem concerns a structural peculiarity in the vascular tree or of the heart at a site beyond the pulmonary arterioles, the ordinary limit of penetration with a catheter. Such structural peculiarities are represented in coarctation or aneurysm of the aorta. A related field of usefulness is illustrated in the following cases:

Case 3.—The patient was a man, fifty-one years of age. He had no significant complaints related to his cardiovascular or pulmonary system. An examination ten years prior to his current visit had disclosed the presence of a fairly loud systolic murmur which was heard over the entire precordial area. During the intervening years, the character of this murmur had not changed. The roentgenograms of the chest revealed the presence of an anomalous shadow in the region of the hilus of the left lung (Fig. 3*a*). Study by fluoroscopic technic led to the conclusion that this shadow probably was cast by an enlarged pulmonary artery. However, a tumor of other origins could not be excluded and the decision was reached that an angiocardiogram should be made. Roentgenograms made 2.5 seconds after beginning the injection of iodopyracet (diodrast) showed marked filling of the main pulmonary artery and its trunks (Fig. 3*b*).

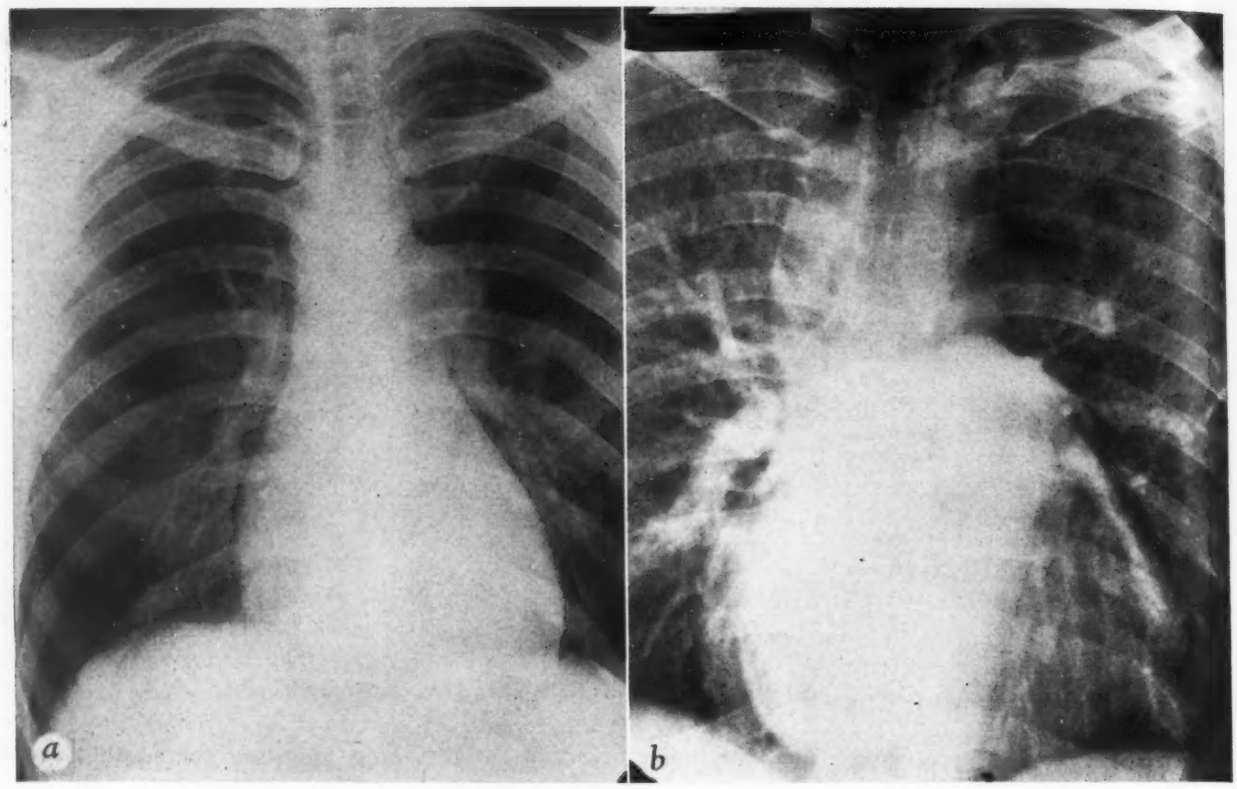


Fig. 4. Case 4. *(a)* Roentgenogram of the chest. *(b)* Angiocardiogram.

The left main pulmonary artery was quite large and formed the shadow in the region of the hilus of the left lung. Surgical exploration of the chest was held unjustified in view of these findings.

Case 4.—The patient was a man, thirty-three years of age. He complained of hoarseness which had developed six months prior to his registration at the clinic. Examination of the larynx disclosed fixation of the left vocal cord. The findings in routine roentgenograms and on fluoroscopic examination of the chest were interpreted as indicative of some enlargement of the left pulmonary artery (Fig. 4*a*). However, an angiocardiogram revealed that the pulmonary artery appeared to be of normal size and no opaque material entered the region of the shadow at the hilus of the left lung (Fig. 4*b*). Because of this finding, surgical exploration of the chest was undertaken. A fixed mass was found in the left hilar area. A biopsy was carried out, the specimen removed showing neoplastic cells of a highly malignant type.

In these two cases, the findings obtained by the usual roentgen-ray studies were essentially the same, yet the underlying structural abnormality was entirely different. By angiocardiography a sufficient degree of distinction was established to permit a logical decision regarding the necessity for undertaking further treatment.

Ballistocardiography

If I am to be honest, I must preface my brief remarks on the subject of ballistocardiography with the admission that my attempts to apply the ballistocardiogram to the analysis of clinical problems have been of limited scope. I have listened to a few individuals talk in a most interesting fashion about this device which records certain waves set up by "the impact of the moving blood in the heart and great vessels."[3] The form of these waves is influenced, among other things, by the amount of blood expelled by the heart and by the acceleration imparted to it as it is thrown out. If quantity expelled were the only variable influencing the curves, then the cardiac output could be calculated quite simply from them. Likewise, if acceleration imparted to the blood could be derived exactly, this would be information of a useful sort. But the two components cannot be separated and computations must be qualified as indicative of "maximum cardiac force."[4]

These efforts do not merit scoffing criticism. Almost certainly significant information of a sort ultimately will be made available by applications of the method. For the present, however, the ballistocardiograph occupies a position not unlike that assigned by Dr. Logan Clendening to the

(Continued on Page 1432)

Missed Abdominal Emergencies

By C. E. Umphrey, M.D.
Detroit, Michigan

EVERY DOCTOR of medicine, regardless of his specialty, will encounter and be challenged by acute abdominal conditions. All of us have missed diagnoses. To diagnose incorrectly after consultation, study of the indicated laboratory procedures and the help the x-rays readings can bring us, should cause few regrets, if the treatment remains surgical once the abdomen is opened. If, however, we add a surgical procedure to a failing coronary occlusion, or an acute pneumonitis, we shall always regret our part in shortening rather than prolonging a life.

The purpose of this paper is to review candidly a number of missed abdominal emergencies which have come under my observation.

Case 1.—The patient was a fifty-one-year-old white man who was admitted to the hospital October 31. He complained of right upper quadrant pain of a recurrent character and of four years' duration. Fats aggravated the symptoms. X-rays showed a non-functioning gall bladder. No stones were demonstrated. The laboratory findings were negative save for a leukocytosis of 17,600. An ECG had been normal two months prior to admission. He had had trauma to his left shoulder so that the pain he developed in his left arm was discounted as the result of this old injury. No repeat ECG was run. On November 5, the fifth day after admission, a cholecystectomy was performed. During the attempt to remove an incidental appendix, the patient suddenly ceased breathing and expired despite attempts to resuscitate him. Autopsy showed a recent coronary occlusion and rupture of the infarcted left ventricular wall.

Conclusions.—We now believe that the falling systolic and pulse pressures should have offered a warning and tipped us off to the expediency of running a second ECG. It is to be regretted that a chronically infected gall bladder, which incidentally did contain stones of a soft non-opaque nature, and the trauma of the left shoulder did camouflage this diagnosis. We would like to have had this patient receive oxygen inhalations in high concentration during one of his attacks of pain. Coronary insufficiency would have been relieved and thus perhaps diagnosed.

Case 2.—A sixty-one-year-old white woman was admitted August 4, complaining of swelling of the abdomen for two and one-half months. In January she had diarrhea for one week. The stool decreased in caliber and became dark. She had been treated for hemorrhoids and colitis for three years. An increase in the size of the abdomen was noted in May. On admission the abdomen was the size of a term pregnancy. Her only other complaint was weakness. Rectal examination showed impaction. She was cyanotic. Before much could be done she expired. This was the day following her admission on August 4. The autopsy showed a tremendous megacolon or Hirschsprung's disease.

Conclusions.—With a little x-ray help this case could have been diagnosed any time during the patient's last five years of life. Whether a low residue diet, saline laxatives, enemas, prostigmine, lumbar sympathectomy, section of the presacral nerve and partial or total exclusion by ileosigmoidostomy or ileorectostomy would have materially altered the final results we do not know. We believe her life could have been prolonged if she had been accurately diagnosed before the onset of an acute toxic state.

Case 3.—A twelve-year-old white girl was admitted to the hospital March 25, complaining of diarrhea of three days' duration. She had six to ten watery stools a day. She had frequency but no burning on urination. On the day of admission she had nausea and vomiting. There was a dull pain in the right kidney area and epigastrium on walking and coughing. Examination and laboratory findings were negative. The following day there was definite right lower quadrant spasm and rebound tenderness. It was decided to do an appendectomy. During the operation, the patient suddenly ceased breathing and there was cardiac arrest. Two intra-cardiac injections of adrenalin were made. Pressure oxygen was used. Approximately twelve minutes after cardiac arrest, the pericardium was entered through the abdomen and the heart massaged. Approximately one and one-half hours after artificial respiration was started, she breathed by her own volition. Fifteen minutes later pulmonary edema developed. She was given atropine and serum albumin. Her lungs were clear three hours later. She was given 500 cc. of blood shortly after cardiac arrest and 500 cc. after her lungs cleared of edema. Despite this and digitalis, she expired nine hours after cardiac arrest had occurred. At autopsy, an atypical bilateral pneumonia was demonstrated. There was pulmonary edema and the usual anoxic petechial hemorrhages of pericardium, lungs and brain were noted.

Presented at the Sixth Annual Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, March 12-14, 1952.

Conclusions.—Our sincere sympathies are extended to anyone who encounters a problem of this nature. It is most unusual for even an atypical pneumonia to be accompanied by the physical and laboratory findings recorded in this case. Most devastating of all was the unexplainable development of deep shock during the operation. This emphasizes the necessity of a well-organized preconceived set of procedures to be utilized in such an emergency. We would summarize shock treatment in the operating room as follows:

1. Stop all operative procedures at once and concentrate on supportive treatment.
2. Lower the head of the table.
3. Give artificial respiration and pressure oxygen in high concentration.
4. Maintain body heat.
5. Intravenous infusion of blood, plasma, saline or glucose depending in that order whichever is more quickly available.
6. Avoidance of vasoconstrictors in profound shock because they reduce venous inflow and cardiac output. Do not "blitz" the patient.
7. Cardiac massage as soon as arrested heart action is diagnosed.

Case 4.—A sixty-year-old white man was admitted to the hospital on January 8, 1952, with a history of having been struck by an automobile. When examined in the emergency room, he complained of pain in the xiphoid region, left lower thoracic region and the area adjacent to the left iliac crest.

Chest x-rays indicated that the diaphragm was abnormally high. It was smooth in outline and showed the usual gas bubble and fluid level just beneath that.

Intercostal block was ordered at that time and relieved all but the xiphoid pain.

On January 9 in an attempt to relieve the cyanosis, he was taken to the operating room and a thoracotomy tube was inserted and air was obtained followed by about 1000 cc. of thick, blood-stained material. Check-up x-rays showed the fluid level below the second interspace. A second tube was inserted at the fifth interspace.

On January 10 blood pressure was 60/40. The patient was still very cyanotic. Gastric contents were observed coming from the thoracotomy tube. Review of the x-rays showed what was probably a rupture of the diaphragm with the stomach in the left chest.

The patient was then taken to the operating room and the left 9th rib removed. Part of the transverse colon, stomach and spleen was observed in the chest cavity. A rent in the stomach, 3 inches long, was repaired. The abdominal contents were replaced in the abdomen. At 11 P.M. that night blood pressure was 178/124.

Conclusions.—There is a standing rule in this hospital that if a patient is injured severely enough to suspect a severe chest or abdominal injury that a Levine tube be inserted. Certainly, if the patient goes to the operating room he will be a better operative risk.

In this case, the Levine tube was not inserted and the accurate diagnosis was not made until the third day following the accident. Fortunately, this oversight did not result in a fatality.

Case 5.—This fifty-four-year-old woman was admitted on November 26, 1951, with a history of having had stomach pain for over four months. At present she had severe abdominal pain with nausea and vomiting. This continued until the day of admission to the hospital when she took nine tablets of phenobarbital and was rushed in as a mental patient who had attempted self destruction.

The impression at the time of admission was:

1. Gastritis.
2. Possible peptic ulcer.
3. Possible intestinal obstruction.
4. Possible pancreatitis.
5. Dehydration.
6. Hypochondriac.

X-ray reports on the date of admission stated there was no evidence of free air under either diaphragm.

In the erect view the stomach appeared to be filled with fluid to about 80 per cent of its capacity. There was also a fluid level of the duodenal bulb. No other fluid levels were seen.

This patient expired at 4 A.M. on November 27, 1951. Her stay in the hospital was short.

She went to autopsy and was found to have had a small perforated ulcer which had sealed and undoubtedly accounted for the lack of air under the diaphragm.

Conclusions.—This patient undoubtedly took the phenobarbital in an attempt to relieve her severe upper abdominal pain. Had she been fortunate enough to receive early medical care and if those administering the medical care had not been too greatly influenced by her depressed state, it is entirely possible that an accurate diagnosis might have been made and the patient's life saved. Certainly her physical condition at the time of admission to the hospital would preclude any other results than the fatal one which followed.

The only warning that can be obtained from this peculiar case is that one should not be crowded into the position of diagnosing a mental state when perhaps a patient is taking strong sedation in order to relieve severe physical distress.

Case 6.—This thirty-nine-year-old colored man was admitted on June 25, 1951, in apparent shock. Four days previous to admittance he gave a history of being beaten while he was intoxicated. He complained of pain in his left chest and that on exertion he became short of breath and blue.

His blood pressure was 90/70. There was crepitation over the left ribs. X-rays showed a fracture in the post-axillary line. He was given a transfusion but did not respond satisfactorily.

He was taken to the operating room on June 27, and a ruptured spleen was removed. Arterial bleeding in the tail of the pancreas was also controlled and a superficial laceration in the superior pole of the left kidney closed. The patient appeared to be doing very well but on the second postoperative day vomited a large quantity of blood. Transfusions could not keep ahead of the bleeding.

On exploration on June 28, gangrene of a section of the small bowel was noted and this portion was resected.

He expired the following day, June 29, 1951. The final diagnosis of the tissue removed was acute infarction of the jejunum.

Conclusions.—This patient received the usual treatment which included long tube suction, 3000 cc. of intravenous fluids daily, Vitamin K, Vitamin C. Flocillin and Streptomycin. The extent to which supportive measures were used is indicated by the fact that thirteen blood transfusions were given during his short period of hospitalization.

In spite of the fact that this patient came to the hospital on the fourth day following the original injury, his progress probably would have obtained a satisfactory end if the acute infarction of the jejunum could have been discovered at the time of the first operation. Apparently, the possibility of infarction was uppermost in the mind of the surgeon because it is recorded that he looked for such a complication..

Some cardiologists have reported ECG evidence simulating that of coronary insufficiency following mesenteric embolism. If this help proves reliable and can be offered early it will be most welcome and will save lives.

Case 7.—This patient was a white man, aged sixty-two, with a history of heart trouble of ten years' duration. He was employed as a truck driver.

Two days previous to admission he was apparently well but suddenly developed severe abdominal pain. A coldness and numbness developed in the left leg followed an hour later by similar changes in his right leg. He was unable to move his legs. It was this condition which caused him to seek help. The blood pressure was 70 with a questionable diastolic.

Impression at time of admission:

1. Thrombus of the common iliac arteries.
2. Syphilitic aortitis.
3. Dissecting aneurysm.

On the day of admission the patient was taken to the operating room. A transverse incision was made. The surprising pathologic condition was a large perforation of the anterior wall of the stomach just above the pylorus. A second incision was made over this area and it was noted that the perforation measured approximately 3 cm. Palpation of the right common iliac artery revealed normal pulsation. Pulsation of the left iliac artery was absent. The patient was in extremely poor condition and for that reason the abdominal wounds were closed and no attempt was made to remove the thrombi from the common iliac arteries.

Conclusions.—If this patient had been observed and accurately diagnosed at the time his ulcer first ruptured there might have been a chance of recovery. Inasmuch as the ulcer was one that was extremely large and inasmuch as it had perforated two days before his entry to the hospital, his condition was of necessity very precarious. The fact that the ruptured gastric ulcer was not diagnosed previous to operation could not in this case materially alter the course. This patient unfortunately waited too long before seeking help. I am sure this case could have been accurately diagnosed before the complication of iliac thrombosis and a life might have been saved.

Case 8.—This thirty-nine-year-old white man was admitted on October 28, 1951, in a state of acute alcoholic intoxication. He complained of severe fullness in his upper abdomen.

The abdomen appeared to be soft but there was some tenderness. The primary diagnosis was chronic alcoholism and acute alcoholic gastritis. It was further noted that the patient had been in the hospital about six months previously because of his drinking with the same diagnosis.

On October 31, 1951, the patient was transferred from psychiatric service to a surgical ward. The second examination gave the impressions of:

1. Convalescent stage, acute alcoholism.
2. Chronic alcoholism.
3. Acute alcoholic gastritis, convalescent.
4. Possible ruptured gastric ulcer.

An x-ray was requested and a flat plate of the abdomen was taken. Some dilatation of the small bowel was noted. There was some free air under the diaphragm in the upright position.

In view of some work that has been done recently, this patient was treated expectantly because of the time that had elapsed from the onset until the discovery of the ruptured ulcer. It was thought that expectant treatment was the ideal one for this type of case. At any rate, his progress was good and he was discharged from the hospital on November 12, 1951, as recovered.

Conclusions.—Perhaps this patient consumed large quantities of alcohol to obtain relief from pain caused by his ulcer. We should take this into consideration and be more aware of the possibilities of ruptured gastric ulcer when these patients complain of upper abdominal pain.

Although the results were satisfactory in this particular case, we believe that an operative procedure, if the perforation had been discovered earlier, would have been indicated. I am also of the opinion that an operative procedure in this case was indicated under existing conditions. Without exploratory examination, it is difficult to tell how large the ulcer is, how well it is sealed off, and how long the closure obtained by nature is going to maintain. Certainly, if a small omental tag is sealed in this opening, any undue pressure is apt to break it loose with a recurrence of all the previous symptoms. We believe early operation with repair and removal of the contaminating fluid will aid in preventing adhesions with obstruction. We are aware that this case should arouse an active and interesting discussion. We hope it does at the surgical discussion period this afternoon.

We believe further that this patient should be carefully followed and when sufficient time has been allowed for complete recovery from his infective peritonitis, he should have a gastric resection if there is any evidence of recurrence or pyloric obstruction.

Case 9.—This forty-three-year-old woman was admitted July 22, 1951, with a small bowel obstruction as seen by x-ray. Symptoms had been present for a period of thirty-six hours previous to admission. The patient gave a history of hysterectomy performed one and one-half years ago. She complained of anorexia and severe cramp-like abdominal pain. The pain was intermittent in type. She had vomited several times.

The abdomen was distended but non-tender and was not rigid. X-rays showed a few dilated loops of small bowel with fluid levels present. The impression at the time of admission was intestinal obstruction from adhesions. A number of these patients have received excellent results when given supportive treatment with long tube suction.

On August 9, 1951, the patient became restless, vomited and apparently had generalized convulsions. She had renal insufficiency for three days prior to death. It was thought that her death was due to the renal insufficiency, bowel obstruction and electrolytic imbalance and a possible pancreatitis.

The final diagnosis in this case from the autopsy findings were:

1. Internal hernia about 10 inches proximal to the ileocecal valve.
2. Intestinal obstruction due to adhesive bands.
3. Cardiovascular disease, hypertensive and aortic sclerosis, nephrosclerosis.

Conclusions.—The question is raised in this case as to whether or not an exploratory operation would have obtained different results if instituted early and the obstruction released. We believe it would.

Case 10.—This fifty-three-year-old white man entered the hospital on September 26, having sustained multiple stab wounds of the abdomen and left arm. The small bowel was herniating through the abdominal wound. Two holes in the jejunum were found. Five deep lacerations of the forearm were sutured. There was also a small stab wound of the left lateral chest wall about the midaxillary line at the level of the ninth interspace.

Before instituting general surgery, a thoracotomy tube was inserted in the left anterior chest at the second interspace. The small bowel was cleaned with saline and the perforations were repaired. Further exploration of the abdominal cavity was essentially negative. The abdominal incision was then closed. All the superficial lacerations, five in number, in the left upper extremity were repaired. The postoperative condition of the patient was good.

October 28 was the thirty-second postoperative day. It was thought that the left lower quadrant should be drained and a colostomy done. On October 30, the patient had a right transverse colostomy performed under general anesthesia. On November 15, fluoroscopy again demonstrated a fistulous tract extending from the distal colon or sigmoid anteriorly into the left lower quadrant.

Conclusions.—From the time this patient entered the hospital until he had his emergency treatment completed which consisted of suturing the superficial lacerations and closure of the perforations of the intestines, we would say that his care had been excellent. In view of what developed later, however, we wonder whether the surgeon would have been better satisfied with a wider incision and a more extensive exploratory procedure. Certainly the perforation of the large bowel which resulted in the fistulous tract complication prolonged the patient's hospital stay and increased the cost of his medical care. Without the facilities at hand in this large hospital and without the excellent care and treatment available, this patient might not have survived this ordeal.

This is one of the complications that can be avoided only if you and I and every other doctor doing surgery make ourselves follow a meticulous

routine of examination and take the extra time that is necessary to make careful examinations. With the general supportive measures available and the type of anesthesia that is offered us today, we certainly have no pressure being brought to bear as in the days of old. The extra precautions required may take an added fifteen to thirty minutes but carries no unusual hazards.

Case 11.—This thirty-year-old white Porto Rican was first admitted April 22, 1950. He said that he had been admitted one year previously for a bleeding peptic ulcer. He did well until the day of admission on April 22, 1950, when he passed dark, tarry stools. His history states that he had epilepsy for fifteen years and he had a two and one-half year history of indigestion and a burning discomfort in the abdomen, which had been quite well relieved by alkalies. He had had no night pains. His first bleeding episode had been in September, 1949; a second slight one in January, 1950, and finally this present sickness.

Laboratory work done revealed a hyperchromatic anemia. He was given two blood transfusions with good results and was discharged. He was re-admitted on April 5, 1950, with the history of a sudden onset of tarry stools, abdominal cramps and some bleeding from the mouth. His blood pressure was 110/80. The rest of the physical examination was essentially negative except for epigastric tenderness. On May 9 and May 11, 1950, x-rays were taken of the gastrointestinal tract and they revealed a filling defect of the ileum, which on further studies disappeared. The stomach was normal at this time. A sigmoidoscopic examination was negative.

He was re-admitted on September 19, 1950, at 5 P.M. He was vomiting coffee-ground material. His blood pressure on admission was 100/50. The patient's condition became rapidly worse and he expired at 6:05 P.M., September 19, 1950.

Gross Pathological Diagnosis.—1. Severe anemia. 2. Carcinoma of the stomach, fundus portion, with metastases to the liver.

Conclusions.—The confusing issues in this case were:

1. The history and findings resembling gastric ulcer.
2. The negative x-ray reports which on later review by the staff proved to be positive.
3. The involvement of the much written about "silent area" of the stomach.
4. The possibility of a Meckel's diverticulum.

It is possible that this man's nationality prevented his seeking aid with the very early symptoms. There must have been some deviation from normal at least two years prior to his death. At that time a gastroscopic examination might have given us a diagnosis in time to do a gastric resection.

Case 12.—This fifty-six-year-old negro complained of a sudden sharp abdominal pain three weeks ago. The pain awakened the patient out of a sound sleep. He had had no stools without the help of enemas. He claims to have eaten something every day.

The x-rays taken at the time of admission showed air under the diaphragm. There were distended loops of small bowel present. The chest was clear. The impression was that of:

1. Perforated peptic ulcer—three weeks' duration.
2. Ileus and small bowel obstruction.

On October 3, 1951, the patient was taken to the fluoroscopy room to check the suction tube. It was found that he had pulled it back to the stomach. His condition was poor so that progress in advancing the tube could not be obtained.

Further history at the time of admission elicited that there had been a gradual onset of lower abdominal pain with cramps in the lower back and the testes. The pain had been fairly constant until the present time, keeping him awake at night. He vomited several times with the onset of this pain three weeks previous. There have been no normal bowel movements in the past three weeks.

Sigmoidoscopic examination on October 2, 1951, was negative. X-ray examination on the same date showed free air under the right diaphragm indicating a ruptured viscus. There was diffuse clouding in the pelvic region.

Conclusions.—This is another unfortunate case in which medical aid was not sought until too late. This patient came to the hospital one day and died the following day. The final diagnosis was not made previous to death, but even had it been made the treatment would probably have remained the same.

In this case, the course would have been entirely different if the patient had been seen directly following the onset of his trouble.

Final diagnosis in this case was:

1. Obstruction of the ileum with a closed loop due to a postoperative adhesive band.
2. Gangrene of a segment of the ileum.
3. Perforation with fecal peritonitis.

Case 13.—The last case to be presented is one of my own. It stimulated the writing of a paper entitled "Missed Meckel's Diverticula." This patient, as is frequently the case, gave an excellent history of an acute exacerbation of a recurrent appendicitis. The examination and laboratory work supported this diagnosis. The conclusions of the x-ray report were: "There is no evidence of a lesion in the upper gastrointestinal tract. There is very definite localized tenderness over a barium-filled appendix and our findings would support a diagnosis of appendical disease." Final diagnosis then was subacute appendicitis.

From the operative report we read, "The appendix was of average size, bound down by adhesions, with a kink in its central portion but apparently not the seat of the

patient's trouble. Fourteen inches from the cecum a small soft mass, about the size of one's thumb, was palpated in the ileum. Opposite the proximal and apparently the point of attachment of the intra-ileial mass was a small opening at the mesenteric border of the gut. This opening was spread with Kelly forceps and an intussuscepted Meckel's diverticulum expressed.

The tissue report is as follows:

Specimen, appendix and diverticulum.

Gross—The specimen consists of an appendix 7.5 cm in length; uniform diameter of 7 mm. It shows no active hyperemia or exudate. The slightly nodular diverticulum measures 2 cm. in diameter, shows some hemorrhagic discoloration and no exudate. When sectioned the diverticulum has a firm polypus mass projecting into the lumen.

Microscopic.—The appendix shows slight pressure changes from retained feces, but no active inflammatory reaction. The diverticulum in typical mucosal pattern of the ileum exhibits mild congestion and a moderate eosinophilic infiltration of the mucosa. In one section there is an area of ulceration, granulation tissue and purulent exudate.

Diagnosis.—Acute Meckel's diverticulitis.

Conclusions:

1. Only 17 per cent of existing Meckel's diverticula are discovered during intra-abdominal operations.

2. Recovery occurs frequently enough following diverticulectomy, even if not acutely inflamed, to warrant its removal.

3. Only ten per cent of those removed are diagnosed preoperatively.

4. The small intussusceptions cannot be seen but are readily found by passing the gut through the fingers.

5. The laboratory and x-ray offer little aid in the diagnosis.

6. In a series studied, 33⅓ per cent had had previous intra-abdominal operations and the Meckel's diverticula were missed. In all three the abdominal symptoms disappeared following diverticulectomy.

7. Diverticulum should be suspected if there is tarry or bright red bleeding per rectum and when the upper gastrointestinal tract is roentgenologically negative.

8. Intermittent colicky pain localized just above and to the right of the umbilicus is a frequent symptom.

9. Simple resection, with the clamps parallel to the long axis of the bowel and inversion of the base transversely, is the usual procedure. Occasionally, a resection of the involved ileum is necessary with closure of the ends and side-to-side anastomosis.

RECENT ADVANCES IN THE DIAGNOSIS OF HEART DISEASE

(Continued from Page 1426)

cremasteric reflex: an interesting thing to do but no one knows quite what it means.

Summary

Perhaps some of you may recall the remark made by a seasoned and discerning professor in one of our local colleges. The old academic said that football bears the same relation to a college education as bull-fighting does to farming. I am certain that as many of you go back to the practice of medicine, you will wonder if that same remote relationship does not pertain in respect to recent advances in the diagnosis of cardiac disease and the care of the patient. However, viewed from a broader perspective than the word "recent" permits, progress has been the order of events in cardiology as in all other branches of medicine. If Einthoven were to look in on current practice of electrocardiography and fail to be amazed at its valuable clinical applications, he would lack that quality of astuteness we commonly ascribe to him. Even those in the junior ranks of medicine can recall the first clinical studies accomplished by ventricular catheterization. These and other methods constantly are serving as the type of hard, factual check on clinical impressions which once could be afforded only by death of the patient and performance of a necropsy. If we fail, therefore, to practice better medicine than our forebears, our deficiencies spring not from want of a diagnosis but from lack of grace, humility, and affection in its application to the patient.

References

1. Burchell, H. B., and Pruitt, R. D.: The value of the esophageal electrocardiogram in the elucidation of postinfarction intraventricular block. Am. Heart J., 42:81-87 (July) 1951.
2. First, S. R., Bayley, R. H., and Bedford, D. R.: Periinfarction block; electrocardiographic abnormality occasionally resembling bundle branch block and local ventricular block of other types. Circulation, 2:31-36 (July) 1950.
3. Jones, R. J.: The ballistocardiograph. Mod. Concepts Cardiovas. Dis., 20:87-88 (Jan.) 1951.
4. Starr, Isaac, Horwitz, O., Mayock, R. L., and Krumbhaar, E. B.: Standardization of the ballistocardiogram by simulation of the heart's function at necropsy; with a clinical method for the estimation of cardiac strength and normal standards for it. Circulation, 1:1073-1096 (May) 1950.
5. Wilson, F. N., Johnston, F. D., Rosenbaum, F. F., Erlanger, Herman, Kossmann, C. E., Hecht, Hans, Cotrim, Nelson, de Oliveira, R. M., Scarsi, Roberto and Barker, P. S.: The precordial electrocardiogram. Am. Heart J., 27:19-85 (Jan.) 1944.

Office Treatment of the Urological Patient

By R. J. Hubbell, M.D.
Kalamazoo, Michigan

SUCCESSFUL treatment of the urological patient in the office presupposes some diagnostic acumen, and, therefore, some aspects of diagnosis may be added to the discussion of this elemental subject.

Office practice, including visits to the home, represents the initial point in our efforts in treating patients, even though they may finally arrive at the hospital, and therefore is important in the early relief of the sick. We might begin by discussing essential points in the history that aid in the diagnosis, and thus make treatment more promptly effective.

Early in the history, it is well to determine the sex, age, and marital status of the individual. It happens in our office practice, we see more women than men. This, I believe, is accounted for by the fact that the short female urethra is more vulnerable to chronic infection arising from the external and internal genitalia, than the male. Early age leads one to suspect the recurring infections incident to poor hygiene or urinary stasis in the very young patient. The young adult, male or female, is more liable to be the victim of an acute venereal disease. Men above fifty are entering the prostatic age, and women of this age suffer from menopausal hormonal and emotional imbalance that at least may aggravate a real or fancied bladder complaint.

Marital status may give a lead in several circumstances: the young unmarried vigorous man who has perineal and leg pains, and burning on urination due to excessive, ungratified sexual excitement; the newly married woman with urinary discomfort, due to the trauma and perhaps infection, from excessive and possibly awkward coitus; the divorced or widowed man in whom the cessation of regular coitus has resulted in a congested and possibly painful prostate and seminal vesicles.

Urinary complaints to be noted are diurnal and nocturnal frequency, discomfort or difficulty in voiding and possibly the presence of blood, with or without pain. The presence of blood in the urine is usually reliably told by a man, although I recall one patient who was referred because of blood in the urine, the source of which proved to be a bleeding wart, on the ventral surface of the shaft of the penis. Blood in the toilet noticed by a woman may lead to uncertainty as to its source but is quickly verified by catheterization. Painless hematuria almost certainly suggests a bladder tumor. Blood mixed with pus in the urine and associated with an acute onset may be presumed to be inflammatory but, if recurrent or chronic in its appearance, certainly demands complete investigation of the urinary tract, preferably by cystoscopy and retrograde pyelograms. Allow me to warn that there are still too many doctors and patients who are inclined to postpone the investigation of hematuria, resulting in the late diagnosis of tumors of the urinary tract. Hess[2] has stated that 90 per cent of the patients he has seen during or shortly after the first evidence of hemorrhage have a five-year, or more, period of survival. If there have been two episodes of hemorrhage, the five-year survival rate drops sharply to around 40 per cent. Even the first attack of hematuria, at times, represents a late stage of a tumor of the bladder or kidney and, in fairness to the patient, we cannot try to outguess the presence or absence of a new growth. My greatest surprise was a man in the 20's, who presented himself with a rather inconsequential terminal hematuria. Although inclined to dismiss it as the result of an over-active sexual life, I cystoscoped him and found a grade I papillary tumor that was easily treated transurethrally and is today apparently cured.

Increased frequency of urination may be the result of inflammation, infection or both. Almost the rule in acute infections, it may be absent in chronic infections. Inflammation may be present without infection, as in chronic granulations or polyps of the female urethra, interstitial cystitis or Hunner's ulcer in either sex, prostatic hypertrophy in the male, or because of ingestion of excessive amounts of fluid, particularly of the alcoholic or carbonated variety.

Difficulty in voiding is usually a symptom of mechanical obstruction which may be secondary to acute infection with resultant swelling and edema of the urethra, or peri-urethral structures, or due to stricture of small or large calibre, prostatic hypertrophy, stone or tumor.

Previous history of gonorrhea may or may not be important. If it occurred before the sulfa-antibiotic era, the possibility of persistent non-specific infec-

tion of the peri-urethral structures or urethral glands or stricture is more likely.

Trauma is a factor to be noted as possibly affecting the urinary tract and responsible for the delayed appearance of obstruction.

The patient's *habits* in regard to eating (excessive spicy foods) or drinking (excessive coffee, tea, carbonated or alcoholic drinks) may be helpful in suggesting a cause for his complaint.

Sexual habits are to be noted, especially in the patient who appears nervous or apprehensive. Unnatural sexual practices may be the sole cause of the difficulty in patients who present themselves with pelvic or perineal discomfort. The practice of withdrawal by the male before ejaculation is particularly harmful to the male and slightly less so to the female. A particularly striking case of this type presented himself to me recently:

H. C. L., male, aged fifty-six, married, a mail carrier, complained of frequency of urination, urgency and inability to control his urine. These complaints had been present for about one year and were getting progressively worse, so that he had to void every half to three-quarter hour, thus interfering with his work and popularity because he wet his clothing but not his bed. Sex habits disclosed very infrequent coitus but he had practiced withdrawal on intercourse for several years. Physical findings were largely negative, except for blood pressure of 170/100. Urine analysis was negative. Residual urine: 2 oz. Cure followed in three weeks by stopping the practice of withdrawal, diathermy to prostate, and passage of sounds on two occasions.

No particular harm is done by the use of contraceptives except possibly to the false pride of some individuals. A rare case of sensitivity to rubber may be encountered—indeed, the sense of safety engendered by their use may help immeasurably in the satisfaction of more normal coitus. Too frequent intercourse may be a factor in some cases of sterility, as an interval of about five days is necessary for the semen to recover its most potent quality and quantity.

Eating and drinking habits, especially spicy foods and excessive drinking of coffee, tea, cocoa, carbonated drinks such as coca-cola, pop, ginger ale, alcoholic drinks, and, in some cases, excessive consumption of citrus fruits, may account for frequency and burning of urination. An adequate fluid intake, however, is important for a healthy urinary tract and in the prevention of calculi.

Constipation is very often a factor in aggravating, at least, a genitro-urinary complaint. This seems to be particularly true in children where the bowel habits are not always known too well by the mother. It seems especially likely that the normal inhabitant of the bowel, B-coli, may invade the contiguous urinary tract in large bowel stasis. An enlarged prostate in the male is, of course, actually the cause of mechanical constipation in some instances.

Family history is not often relevant in diseases of the urinary tract.[1] Polycystic kidneys are liable to follow a pattern of heredity. Cystine and zanthine calculi seem at times to occur in brothers and sisters particularly. It is well to know of the presence of tuberculosis in the immediate family as a possible source of urinary tract infection, but the antecedent history of tumor is not particularly significant.

The physical examination should consist of a complete appraisal of the patient and not be confined to the urinary tract alone. Does the patient look well generally? If so, the urinary complaint may be a disorder localized to one system. However, if he is sick in appearance, the urinary complaint is more likely a part of some more generalized disorder. If the patient is obese, is diabetes present to account possibly for a polyuria and frequency?

The eyes reflect the general vigor of the patient, the corneae being cloudy in the aging individual. Arcus senilis denotes an aging process that may reflect a hypertension or inadequate kidney secreting substance, possibly associated with albuminuria. Infected tonsils or teeth may represent foci of infection that affect the urinary tract by metastatic invasion.

Auscultation and percussion of the chest leads one to suspect a chronic lung disorder, or tuberculosis or cardiac embarrassment which may be an adverse factor if surgery to the urinary tract is contemplated. Blood pressure determination is routinely recorded as an element in the general appraisal of the patient, and if elevated, and without obvious cause, an intravenous pyelogram at least is indicated.

The abdomen should be palpated with the patient in the supine position and a careful appraisal of the lumbar and costo-vertebral areas made. Using bimanual palpation and palpating in the exhaled and inhaled position, the kidneys may or may not be palpable. Costo-vertebral angle tenderness is very significant if definitely localized. With the patient sitting up, inspection of the back may show fullness in either costo-vertebral area,

as in a peri-nephritic abscess, or gentle fist percussion in these areas may be helpful in localizing a pathologic condition of the kidney.

Ureteral tenderness may be elicited on deep palpation along its course. The presence of hernia is noted with the patient in the upright position, as it may be the source of lower abdominal or pelvic pain associated with genito-urinary pathology.

The suprapubic area should be percussed to determine the possible presence of an appreciable amount of residual urine.

Examination of the external genitalia includes deviations from the normal gross anatomy in the male and female, and should be very thorough, beginning with the external urethral meatus. In the male, the epididymus should be carefully differentiated from the testes and the size of the testes noted for any atrophy that might be present, or tumor. A urethral discharge should be noted and if one is complained of, but not present at the examination, the patient may be given two glass slides with instructions to collect a drop of discharge on one slide, spread it out by sliding the end of the other slide over it, allowing to dry ten minutes, then placing the slides face together and returning for stain. A methylene blue stain is the simplest and quickest to use, but the gram stain is necessary to further differentiate invading organisms. After a urethral discharge is obtained or excluded, the urine is obtained either by voiding or catheterization.

The two-glass test is used quite routinely in the male. The first glass contains the washings of the anterior urethra, the second glass giving a more true picture of the bladder urine, without contamination by foreign sediment in the anterior urethra. Shreds in the first glass alone denote a chronic low grade exfoliative urethritis limited principally to the anterior urethra. Cloudy urine in both glasses may be due to a simple phosphaturia, easily differentiated by clearing with acetic acid, or to the presence of white blood cells, red blood cells, bacteria, alone or in combination. The two-glass test may also be used in the female, but it is more difficult mechanically and a catheterized specimen is the procedure of choice.

If cultures are to be obtained, a sterile container must be used, of course; otherwise, a clean receptacle is satisfactory. Specific gravity, pH, albumin, sugar, and centrifuged sediment are recorded. A drop of the centrifuged sediment is placed on a slide, covered with a cover glass and the slide examined with the high power field. Bacteria can usually be noted if present in any appreciable amount and, in general, may be differentiated into cocci and bacilli in the wet smear. This may be sufficient to designate the type of drug to be used. I believe the simpler inexpensive drugs should be tried initially, reserving the high-priced antibiotic drugs to be used if necessary. In general, Sulfadiazine or one of the combined sulfa drugs may be used in ½ or 1 gram doses every six hours for three to seven days in the coccal infections. Gantrisin, Sulfacetimide, or Mandelamine may be used in the bacillary types of infection. In the acute infections not of long standing and uncomplicated, this treatment will be usually successful. If the result is not satisfactory, after being certain there is no obstruction in the urinary tract, an antibiotic may be used. It may be best, however, to isolate the organisms by culture and determine the drug to which the particular organism is most sensitive.

Jawetz, et al,[3] have cautioned against the indiscriminate use of combinations of antibiotics, although a beneficial synergism has been noted in some cases, and in others a definite antagonism has been found.

If no result is obtained after two to three weeks of this treatment or if the infection is recurrent, a complete investigation of the urinary tract by cystoscopy and retrograde pyelograms is warranted. Intravenous urograms are valuable as a screening process and show opaque stones in the urinary tract and gross abnormalities, but cystoscopy adds to the record of vision in the lower tract with differentiation of kidney urines, more accurate determination of separate kidney function, and more accurate pyelography.

Rectal examination. The normal prostate is described as about the size of a horse chestnut and has a medium firm texture and smooth surface. A soft, boggy gland may represent a retention of normal prostatic fluid constituents or a markedly infected gland. An acutely infected gland is extremely tender and should not be massaged except possibly two or three strokes of the examining finger may be used to express a drop of the secretion for examination. It is examined under a cover slip with high power and normally there should be no more than 2 to 4 wbc./hpf. If secretion is not obtained, you may have the patient pass an additional few drops of urine or, if necessary, the

patient may be catheterized if it is important to obtain the information on the secretion at that particular visit. Acute prostatic infections are well treated with penicillin and dihydrostreptomycin, but without massage, and diathermy with a prostate electrode may be very comforting. Bed rest, light diet and relaxation are helpful adjuncts.

Rectal examination is a must in the male patient over fifty years of age, if we are to detect early carcinoma of the prostate. It is only by doing many rectal examinations that one can familiarize himself with the normal prostate and thus be able to detect changes in the gland that suggest early malignancy. The number found will not be large, but as in tumors of the breast, periodic palpation and removal of the small lesion is our only hope of cure of cancer of the prostate. The palliative therapy of advanced carcinoma of the prostate is, of course, highly satisfactory, but the stony hard prostate is a late, not an early, malignancy. The administration of diethylstilbestrol or similar substance in dosage of 3 to 5 mg. daily may change a definitely carcinomatous gland to a fairly normal feeling prostate. The change is at times unbelievable and the patient may again be able to void under this treatment alone.

Nesbit[4] has shown that orchiectomy to remove the principal androgenic producing substance in combination with stilbestrol is the procedure of choice in the control of prostatic carcinoma of the late variety. Transurethral resection is reserved for those cases in whom the obstruction is marked or unrelieved by hormonal therapy.

Chronic prostatitis is an entity similar to chronic tonsillitis in its many manifestations. It may cause general ill feeling with malaise, vague pelvic, leg or perineal pain. Occasionally, it may be a source of pyuria or even episodes of acute genital infections, as epididymitis. The mere presence of an increased number of white blood cells in the prostatic fluid is not an indication for prolonged prostatic massage. If a chronically infected prostate is a significant factor in the patient's complaints, prostatic massage should give quite prompt relief, although the actual eradication of the infection may be time-consuming. Medication with sulfa drugs or antibiotics has, in our experience, not been particularly helpful in the chronically infected prostate but in the acute infections they are very valuable. Diathermy in the chronic infections, in our experience, is of doubtful value. Intraprostatic injections of penicillin alone, or combined with dihydrostreptomycin, are sometimes of value in at least reducing the infection and occasionally effecting a cure.

The acute venereal infections are not so often seen in the urologist's office as formerly because the treatment has become much more simple. Gonorrhea is diagnosed by the stained smear of the discharge with the Gram or methylene blue stain—intracellular diplococci being for all practical purposes diagnostic. If there is a question of the presence of gonorrhea, the culture is a valuable tool to be used in the male and female. Treatment by penicillin is very effective. It is our practice to give a daily injection of 400,000 units of penicillin for two days, the cure rate being close to 100 per cent. One injection will probably suffice, but if I had the infection I would want two, and that is what I advise. One must be sure to warn the patient to have a monthly Kahn or similar test for three months because the low dosage of penicillin may mask a contracted early syphilis. Other antibiotics, such as Aureomycin and Terramycin, may also be used, apparently with very good results, but to date I favor penicillin.

Chronic non-specific urethritis in the male is not as common as in the female, but may be manifest by a low grade early morning urethral discharge of the muco-purulent variety, and discomfort in the urethra is also occasionally complained of.

A chronic anterior urethritis may be suspected by a cloudy first glass of urine with a clear second glass. Administration of a sulfa drug or Gantrisin or one of the sulfa combinations may be successful in clearing the infection. If not, a very cautious use of sounds may be employed to improve drainage in the urethral glands, starting with a No. 20 French metal sound and increasing two sizes French once a week, perhaps followed by instillation of 5 per cent Argyrol.

Urethral strictures of small or large calibre may be found in either the male or female. Since the advent of improved urinary antiseptics and less local treatment of gonorrhea, there are fewer strictures from this source but strictures from prolonged catheter drainage or following transurethral resection are seen. It may be necessary to use a filiform with following bougies or sounds in the manner described above (urethral instruments—

(Continued on Page 1494)

Differential Diagnosis of Jaundice

By Raymond O. Muether, M.D.
St. Louis, Missouri

THE DIFFERENTIAL diagnosis of jaundice may be extremely simple when the history and physical findings are typical and when the liver function tests, too, are clear cut and easily interpreted. Frequently, however, the complex physiology of the liver may cause considerable confusion.

The clinician is primarily interested in whether the jaundiced patient needs medical or surgical treatment. The correct solution of this dilemma is of practical importance since patients with "medical jaundice" do poorly if subjected to surgery and the "surgical types" deteriorate if neglected.

It is unfortunate that despite intensive study there is, as yet, no infallible methods for the differential diagnosis of jaundice. It is still necessary to evaluate the results of hepatic tests in the light of probabilities rather than certainties.

A great deal of this discussion will deal with tests of hepatic function but I would not have you believe that they are all important as I believe strongly that history and physical findings should take precedence over laboratory studies in a given case. The majority of cases of jaundice can, I am sure, be diagnosed correctly without elaborate laboratory studies.

In the presence of jaundice a careful history is the first and perhaps most important step in deploying our resources to reach an eventual diagnosis.

Age should be given some consideration, but undue emphasis should be avoided, since stones and malignancy may occur in the young and hepatitis in the elderly.

Jaundice due to malignancy and alcoholic cirrhosis occurs more frequently in males than females but the sex incidence of liver disease is more apparent than real, and depends on social customs, occupation, exposure, et cetera.

History should concentrate on determining previous digestive disturbances, type and character of pain, rapidity and amount of weight loss, intake of hepatotoxins, such as cincophen, alcohol and industrial toxin, previous blood or plasma transfusions, hypodermic medication and contact with jaundiced patients. Great care must be exercised to obtain accuracy. The patient should be questioned repeatedly and at different times, relatives should be interviewed since not infrequently they have an entirely different concept of the onset and symptoms than the patient.

It is surprising, but well known, that many patients seem to have remarkably little insight into their illness and the true facts can only be obtained by careful and skillful questioning.

The physical examination of the patient should be carried out with great care and attention to detail. The degree of jaundice, changes in the skin, the presence of spider angiomata, the size, consistency and tenderness of the liver and spleen should be sought for and carefully noted. Evidence of neoplasms anywhere in the body should be searched for, the prostate, colon and lung being particularly prone to metastasize to the liver. A palpable distended gall bladder indicates relatively rapid extrahepatic obstruction and a gall bladder that is elastic. *Carcinoma* of the *ampulla* or of the head of the pancreas may produce such a finding but only rarely will a primary carcinoma of the gall bladder be responsible for a palpable mass in the right upper quadrant. The history and physical findings should aid us in our approach to the problem but in order to have a logical approach we must follow some classification or other of jaundice.

It is immaterial which classification is followed so long as the particular classification is well understood.

I find Ducci's simple classification of Jaundice to be understandable and useful.

TABLE I.

1. *Prehepatic Jaundice*
   a. Hemolytic
   b. Non-hemolytic
2. *Hepatic Jaundice*
   a. Hepato-cellular
   b. Hepato-canalicular
3. *Post Hepatic Jaundice*
   a. Incomplete obstruction
   b. Complete obstruction

In order to fit the jaundiced patient into the classification a certain amount of basic laboratory work as well as certain special tests of liver function may be needed. It is wise, I believe, to

Presented at the Sixth Annual Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, March 14, 1952.

TABLE II. FUNCTIONS OF THE LIVER

1. Storage
   - A. Glucose as glycogen
   - B. Protein
   - C. Neutral Fats and Phospholipids
   - D. Antipernicious anemia factor vitamins: A and D probably factors of the B complex minerals: Copper and Iron
2. Synthesis
   - A. Food Material
     1. Glycogenesis
     2. Amino Acids to Glucose
     3. Fats from glucose, protein and glycerol
     4. Amino acids (some)
     5. Dehydrogenation of fats
     6. Production and oxidation of some organic acids
     7. Carotene to vitamin A.
   - B. Other substances—(all or in part)
     1. Fibrinogen, heparin
     2. Ketone Bodies
     3. Bile salts
     4. Cholesterol
     5. Urea and uric acid
     6. Some bilirubin from hemoglobin
     7. Urobilinogen to bilirubin
     8. Glucuronic acid conjugates
     9. Albumin and globulin
     10. Histamine
     11. Possibly some antibodies
3. Detoxification
   - A. Chemical means
     1. Conjugation
     2. Methylation
     3. Oxidation
   - B. Excretion in bowel
   - C. Storage in liver cells
   - D. Phagocytosis by reticulo-endothelial activity
4. Regulates
   - A. Body heat
   - B. Blood volume
     1. Reservoir for red cells and fluid
     2. Aids in ionic equilibrium
5. Excretory
   Bile, dyes, calcium, cholesterol enzymes, fatty acids, et cetera.
6. Endocrine relations
   Pancreas—thyroid, pituitary, adrenals and gonads.

always secure a urine analysis, red and white cell count, a sedimentation rate and a blood sugar.

Certain x-ray studies may be necessary such as a gastro-intestinal series to rule out carcinoma of the stomach and colon. Deformity of the duodenum may suggest a pancreatic malignancy and should be looked for.

An x-ray examination of the lungs may be indicated to rule out either primary or secondary malignancy.

An x-ray of the bones, the so-called "metastatic series" may also be indicated in obscure cases of jaundice.

These procedures carried on either before or during the liver function tests often help to clarify what might otherwise be obscure.

TABLE III. NORMAL VALUES FOR LIVER FUNCTION TESTS

Biliribuin (serum)	
1 minute	0.4 mgm. per 100 ml.
Total	0.7 mgm. per 100 ml.
Urobilinogen (Urine)	0 to 5 mgm./24 hrs.
Urobilinogen (feces)	50 to 300 mgm./24 hrs.
Cholesterol (Total) serum	160 to 210 mgm./100 ml.
Cholesterol (Esters) serum	90 to 120 mgm./100 ml.
Bromsulfalein (5 mgm. dose)	45 min. less than 5%
Cephalin Cholesterol Flocculation	Negative to 2 plus
Takata Area Reaction	Negative
Thymol Turbidity	0 to 10 units
Thymol Flocculation	0 to 1 plus
Hippuric Acid	
Oral	2.5 to 3.5 gm.
I. V.	1.0 to 0.7 gm.
Phosphatase (Alkaline)	
King Armstrong	1 to 12 units
Protein (serum)	5.5-7.8 gm./100 ml.
Albumin	3.3-4.3 gm./100 ml.
Globulin	2.2 to 2.8 gm./100 ml.
Albumin—globulin ratio	1.6-2
Prothrombin (Blood)	11-13 seconds

Liver function tests have received a great deal of attention in the past decade and their number alone is enough to cause confusion. The functions of the liver are many and diverse and include storage, synthesis, detoxification and such nondescript functions as helping to maintain water balance and acting as a reservoir for red cells.

There is no single test of liver function which is completely satisfactory and if tests are to be done, a battery of tests should be employed and they should be done simultaneously so that the patient will suffer the least inconvenience.

It is wise to follow the progress of the patient by repeating the tests, perhaps omitting some and adding others as indicated.

Liver function tests must be done carefully by competent personnel or they may give more misinformation than information. This does not mean that the tests are extremely difficult. They are not; they only require meticulous attention to detail.

Table III gives a list of the more commonly used liver function tests with their normal values. Their significance will become apparent as we progress.

Prehepatic jaundice need not detain us too long, since, if thought of, it can easily be confirmed. *In the hemolytic type* (Table IV) the indirect reacting bilirubin will be high and will make up most of the total bilirubin, there will be increased urobilinogen in the stool and perhaps in the urine. There will be no bilirubinuria. Classi-

TABLE IV. PREHEPATIC JAUNDICE

	Hemolytic	Non-Hemolytic
Bilirubin		
1 minute	Normal	Normal
Total	Increased	Increased
Bile Pigment/Urine	None	None
Urobilinogen		
Urine	Increased	Normal
Stool	Increased	Normal
Liver Functions	0 to 1 plus	Normal
Reticulocytosis	Yes	No
Spherocytosis	Yes	No
Red Cell Fragility	Increased	Normal

TABLE V. HEPATIC JAUNDICE

	Hepato-cellular	Hepato-canalicular
Bilirubin		
1 min.	Normal	Increased
Total	Increased	Normal/Increased
Bilirubinuria	Positive/Negative	Positive
Urobilinogen		
Stool	Normal or low	Low
Urine	Increased	Decreased
Cholesterol		
Total	Normal-Decreased	Increased Normal
Esters	Decreased	0-2 plus
Cephalin Flocculation	Positive	Negative/Positive
Thymol Turbidity	Positive	Negative/Positive
Thymol Flocculation	Positive	Negative/Positive
Alkaline Phosphatase	Normal	Increased
Serum Protein	Decreased	Normal
Albumin	Decreased	Normal
Globulin	Normal/Increased	Normal

cally there is no disturbance in liver function and reticulocytosis, spherocytosis and anemia will be present.

The *non hemolytic prehepatic jaundice* is a poorly understood, unexplained type of jaundice with a familial or hereditary overlay. Here, too, the liver is spared and function tests are characteristically normal; there is no reticulocytosis or anemia. The indirect reacting bilirubin may be increased and urine and stool urobilinogen will be normal.

Hepatic jaundice (Table V) can be divided into hepato-cellular and hepato-canalicular, but mixed is the type most commonly encountered and gives the greatest difficulty in diagnosis. This difficulty is markedly increased if the patient is first seen three to six weeks after the jaundice began.

In hepato-cellular jaundice we may expect the fecal urobilinogen to be normal or slightly decreased and the urine urobilinogen to be increased due to the inability of the liver to utilize the urobilinogen brought to it from the gut, and hence, the excess is excreted by the kidney. Thus an increase in urine urobilinogen in the face of normal or decreased focal urobilinogen is a sensitive test of liver function.

Bilirubinuria may occur in the pre-icteric stage but will be absent when icterus develops and the indirect reacting bilirubin in the serum will be increased.

Total cholesterol will be normal or slightly decreased and the cholesterol esters will be decreased indicating a disturbance in the ability of the liver to esterify cholesterol.

The cephalin-cholesterol flocculation and thymol turbidity tests will be positive. The thymol turbidity being more constant than the cephalin flocculation test which is frequently positive in other diseases such as malaria and infectious mononucleosis. The thymol turbidity may remain positive after the cephalin cholesterol flocculation has returned to normal.

The alkaline phosphatase is usually normal or only very slightly elevated.

The total plasma protein may be normal or slightly decreased, the albumin may decrease, the globulin may be normal or increased.

In a case of pure hepato-canilicular jaundice one may expect an increase in the direct reacting bilirubin, bilirubinuria, elevated cholesterol and an increase in the serum alkaline phosphatase. Watson[5] is of the opinion that this type of jaundice may follow acute hepatitis and be designated cholangiolar hepatitis and that under these circumstances the tests of parenchymal damage will show only minimal changes. Such a picture is rare. Steigman and Popper,[4] on the other hand, feel that intrahepatic obstruction which occurs during hepatitis indicates a severe liver disease and find the liver function tests more markedly deranged than in a simple hepatitis unassociated with intrahepatic obstruction. Their concept is that a mixed form is most common.

On the basis of my own experiences I, too, favor this concept, but be that as it may, it is important to realize that intrahepatic obstruction does occur with considerable frequency with hepatitis and may last from one to ten days and on occasion may persist for as long as three weeks. Therefore, it is extremely important to follow the fecal and urine urobilinogen with regularity.

In the mixed type in which both hepato-cellu-

TABLE VI. POSTHEPATIC JAUNDICE

	Incomplete Obstruction	Complete Obstruction
Bilirubin		
Direct	Increased	Increased
Indirect	Normal-Increase	Increased/Normal
Bilirubinuria	Yes	Yes
Urobilinogen	Variable	
Stool	Decrease/Normal	
Urine		None
Cholesterol	0 to 1 plus	None
Total	Increased	Increased
Esters	Normal/Increase	Normal/Increase
Cephalin-Cholesterol Flocculation	Negative	Negative early
Thymol Turbidity	Negative	Negative early
Thymol Flocculation	Negative	Negative early
Alkaline Phosphatase	Elevated	Very high
Serum Diastase	Normal to Elevated	Normal/Elevated

lar and hepato-canalicular elements are present, the hepato-cellular aspects may overshadow the obstructive aspects and the disease is frequently classified as hepato-cellular jaundice.

Extra hepatic or posthepatic jaundice may be subdivided into complete and incomplete obstruction and these two constitute, as a rule, surgical jaundice.

In *incomplete posthepatic jaundice* the direct reaction or one minute bilirubin is increased, bilirubinuria is present, fecal urobilinogen is decreased or may be completely absent for a time. The urine urobilinogen will be absent or markedly decreased. The total cholesterol is increased and cholesterol esters will be normal or increased. The alkaline phosphatase will be moderately increased above 10 units and *the flocculation tests* will be normal unless the disease has existed for months or years. The serum diastase is usually normal unless the jaundice is the result of chronic recurrent pancreatitis in which event the diastase may be elevated.

In complete obstruction which is permanent there will, of course, be no urobilinogen in the stool or urine at anytime. An exception to this might be an infection which occured above the obstruction, in which case, the bile in the biliary tract might be altered by bacteria and urobilinogen would then appear in small amount in the urine and not in the feces. The direct reacting bilirubin of the serum is increased, bilirubinuria is present, alkaline phosphatase is very high, 20-40 units, and the flocculation test are normal unless obstruction has persisted long enough to produce changes in the liver parenchyma. This usually requires a complete obstruction lasting from six weeks to as many months.

It is impossible at times to make a differential diagnosis of jaundice from the history, physical findings and laboratory studies and in such cases a needle biopsy of the liver is indicated.

In a considerable experience our mortality from this procedure has been less than 0.5 per cent. There are few hard and fast contraindications to the needle biopsy of the liver. Cardiac decompensation with congestion of the liver or a complete biliary obstruction are two things which may give trouble, the former through bleeding and the latter through leakage of bile into the peritoneal cavity. Obviously patchy diseases of the liver may be missed occassionally but if an attempt is made to pick the site of biopsy this does not occur too frequently. Obviously too, the abdominal approach is somewhat less hazardous than the transpleural approach.

Conclusion

1. The differential diagnosis of jaundice may be difficult at times but is best accomplished by careful history, physical examination and a battery of liver function tests which are carefully performed and well understood by the physician who employs them.

2. A liver biopsy is indicated when laboratory findings are conflicting or confusing or before exploratory laparotomy.

3. When doubts cannot be resolved a period of observation and study of three to six weeks is indicated and if, at the end of that time, the diagnosis is not established and the possibility of a surgical jaundice still exists exploratory laporotomy is not only indicated but mandatory.

References

1. Ducci, H.: Contribution of the laboratory to the differential diagnosis of jaundice. J.A.M.A., 135: 694-698 (Nov. 15) 1947.
2. Lipp, Wm. F.; Lenzner, A. R., and Aaron, A. H.: The accuracy of diagnosis of jaundice. J.A.M.A., 136:236-239 (May 15) 1948.
3. Snell, A. M.: Fundamentals in the diagnosis of jaundice. J.A.M.A., 138:274-279 (Sept. 25) 1948.
4. Steigmann, F., and Popper, H.: Intrahepatic obstructive jaundice. Gastroenterology, 1:7 (July) 1943.
5. Watson, C. J., and Hoffbauer, F. W.: Liver function in hepatitis. Ann. Int. Med., 26:6 (June) 1947.

Refinements in the Diagnosis of Early Tuberculosis

By J. Arthur Myers, M.D.
Minneapolis, Minnesota

TUBERCULOSIS and syphilis are diseases whose specific organisms may live long periods of time in the human body without causing serious illness. At any moment, however, they are capable of resulting in clinical disease. Each disease starts with primary lesions which *per se* are usually relatively insignificant, since the body's defense mechanism promptly brings them under at least temporary control. Often, however, this mechanism is unable to destroy either the Spirochaeta pallida or the tubercle bacilli. Primary lesions of syphilis are much more likely to be diagnosed promptly than those of tuberculosis because they are frequently located on the surface of the body or within orifices easily inspected. The majority of primary tuberculous lesions occur in internal organs, a preponderance of which cannot be located by any phase of examination during the lifetime of the individual.

Specific diagnostic tests have been devised for both tuberculosis and syphilis. Good chemotherapeutic agents, capable of destroying Spirochaeta pallida, are now available for syphilis. Chemotherapeutic agents are now in use for tuberculosis which have good bacteriostatic actions, but as far as is yet known, they are not bacteriocidal.

No dependable immunizing agent is available for either of these diseases; therefore, their prevention is dependent upon avoidance of initial invasions of the organisms.

Thus, our profession still labors under considerable difficulty with tuberculosis. Despite the handicaps, we have brought this disease under better control in this country than has been done in any other major nation. Moreover, there are large areas in this country which have suppressed tuberculosis far more successfully than has any minor nation of comparable size. Although our accomplishment is the most outstanding in the world, we have not yet reached the half way mark to the eradication goal.

Presented at the Sixth Annual Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, Michigan, March 13, 1952.

The most important factor in our present and future work leading to eradication of tuberculosis is diagnosis at the earliest possible time after first invasions with tubercle bacilli occur. This necessitates a clear comprehension of the early pathogenesis of the disease. Tuberculosis is rarely congenital. Therefore, practically all primary invasions occur after birth. In some parts of the world nearly all children still become infected with tubercle bacilli. In other parts, including the United States, tuberculosis has been so nearly eradicated from animals, particularly cattle, and so much has been done to isolate and treat tuberculous people that relatively few infants and children become infected. In fact, primary invasions with tubercle bacilli now occur more often among adults than among children, and large numbers of adults avoid infection throughout life.

When tubercle bacilli first invade the human body, regardless of the portal of entry or the age of the individual, they are promptly phagocytosed by neutrophils, many of which promptly enter the lymph and blood streams. Thus, there is an early bacillemia. Tubercle bacilli are so toxic to neutrophils that they soon lose their ability to change shape, and as they approach small capillaries they cannot elongate and enter. Wherever a neutrophil lodges in this manner its tubercle bacilli are focalized. Obviously, these points of focalization are multiple and occur in various organs of the same individual, such as the brain and kidneys. They are most frequently found in those organs richly supplied with fine capillaries, particularly the lungs.

At these various points of focalization, tubercle formation is likely to occur. From these areas, some of the tubercle bacilli escape to regional lymph nodes in which they are trapped and produce lesions. In the vast majority of cases the body's defense mechanism builds walls around the original and lymph node lesions. Within these lesions tubercle bacilli may remain alive and virulent for brief or long periods of time.

While primary lesions and their lymph node components are developing, the tissues of the body, including the skin, become sensitized to tuberculoprotein. This sensitivity usually can be elicited by the tuberculin reaction within two months or less after the initial invasion occurs. We know of nothing in nature which results in such a degree of sensitivity but the tubercle bacillus. Therefore the tuberculin reaction informs the physician of

the presence of tubercle bacilli and the lesions they have produced.

Immediately after allergy has been established, lesions can rarely be located by x-ray inspection or other phases of the examination. If they are in the 75 per cent of the lungs visualized by x-ray inspection, most of them are too small or not dense enough to cast visible shadows. They may be in the 25 per cent of the lungs obscured from view by shadows of other organs, such as the heart. Again, they may be extrathoracically located. When tissues first become allergic, evidence of disease is revealed by x-ray film inspection of the chest in less than 10 per cent of cases.

In a small percentage of persons recently infected there may be fleeting symptoms such as those of a cold or a mild attack of influenza, and the erythrocyte sedimentation rate may be moderately accelerated. Tubercle bacilli may be recovered from gastric washings in a few cases.

The tuberculin test is the sole agent by which one is able to diagnose the presence of primary lesions containing tubercle bacilli with great accuracy in practically all persons who have them.

From time to time, propaganda has been launched against the tuberculin test. Papers have been published in condemnation of it because the occasional person with a demonstrable pulmonary lesion with acid-fast bacilli reported in the sputum or gastric washings does not react. Account is not always taken of the fact that laboratory errors are frequent and that not all acid-fast organisms are tubercle bacilli. In some of these reports there is a rare, unmistakable case of tuberculosis who does not react to the usual test doses. In the over-all picture these isolated cases are of little significance. Such large and excellent studies as those conducted at Maybury Sanatorium, Northville, Michigan, and the Chicago Municipal Sanitarium have shown that practically all proved cases of tuberculosis react to the usual test doses of tuberculin. The main exceptions are those with advanced, acute or chronic disease, and elderly persons. These are not significant because their disease is readily diagnosed without tuberculin. Even in these persons the reaction can be elicited by larger doses of tuberculin.

Attention has often been called to nonspecific tuberculin reactions, especially when the usual second dose is administered. These are not characteristic reactions. Therefore the physician need not worry about them if he adheres to the distinguishing qualities of the true reaction. Nearly forty years ago the veterinary profession encountered noncharacteristic reactions among cattle in certain areas of the United States. They found that these were caused by nonpathogenic acid-fast bacilli which inhabit soil. It is probable that this or even other nonpathogenic acid-fast bacilli are responsible for so-called nonspecific reactions in people.

It is often said that physicians vary so much in reading and interpreting tuberculin reactions as to partially nullify the value of the test. This is not a condemnation of the test, but a failure of physicians to become informed of the characteristics of the reaction—namely, induration or edema, or both. Moreover, physicians do not vary as much in reading tuberculin reactions as they do in reading and interpreting x-ray shadows. Therefore there is no reason for the medical profession to become confused. The tuberculin reaction has stood the test of time and remains our number one ally in combating tuberculosis.

Physicians who have used the tuberculin test most and have kept up long periods of observation on reactors and nonreactors regard it as the most specific and accurate test now available for any disease. In diagnosis, it finds tuberculosis earlier than any other phase of the examination. With well known but unimportant exceptions, one is almost certain that the nonreactor does not have tuberculosis. It is our best epidemiological and case-finding method. Every child and every adult who has recently become a reactor to tuberculin has lately been in effective contact with a tuberculous person or animal. This information can be obtained in no other way. It immediately places the physician on the trail which, if he follows diligently, often leads him to a person or an animal with contagious disease.

The tuberculin test is the only agent we possess for determining promptly and accurately the effectiveness of a tuberculosis control program. Willful administration of anything, including living or dead tubercle bacilli of any degree of virulence such as BCG or vole bacillus vaccine which artificially sensitizes tissues to tuberculoprotein thereafter, deprives the physician of the use of his best diagnostic and epidemiological agent and denies the individual of his inalienable right to know if and when he becomes infected with virulent tubercle bacilli.

Far too long our profession has labored under

the concept that illness must occur or gross lesions be demonstrable before an individual can be said to have tuberculosis. In reality, tuberculosis exists as soon as tubercle formation begins. The lesions which later become demonstrable and cause illness are often the result of evolution of these microscopic beginnings.

The only method we have of diagnosing tuberculosis early is to test uninfected persons, both children and adults, periodically with tuberculin. Those who have become reactors since the last test have developed primary lesions containing living tubercle bacilli. In addition to making an accurate diagnosis, the test informs the physician that the newly reacting individual has been in contact with someone who has contagious tuberculosis and who should be found.

As soon as we have a drug that will destroy tubercle bacilli in human tissues, the best time to administer it will be promptly after the individual becomes a tuberculin reactor, regardless of clarity of x-ray films of the chest and freedom from symptoms. At this time the lesions are nearly always small and vascular. A germicidal drug in the blood stream would then be expected to reach all tubercle bacilli and result in complete sterilization. Only in this way may one ever expect to cure tuberculosis in the sense of destroying all foci of tubercle bacilli. If we wait until lesions become avascular with necrotic and caseous areas, there is little hope of a drug reaching their bacilli regardless of its concentration in the blood stream.

Until a bacteriocidal drug is available, our best procedure consists of periodically examining all persons who are or who become characteristic reactors to tuberculin. Only in this way is it possible to regularly locate chronic reinfection type of pulmonary lesions as early as they evolve to macroscopic size and are of such density as to cast visible x-ray shadows. By this method most chronic lesions can be visualized long before symptoms appear or tubercle bacilli are being eliminated in sputum.

Many persons who develop primary tuberculous lesions and become tuberculin reactors never have the disease progress to clinical proportions. However, everyone who does develop clinical disease passes through the stage when no phase of the most complete examination reveals its presence except the tuberculin reaction.

As yet, we have no way to determine which persons who react to tuberculin will at some subsequent time develop clinical disease. Therefore, everyone who is found to be a reactor should have those parts of the body which clinical tuberculosis frequents examined periodically. If the individual is in infancy, the parents should be instructed to inform the physician at once if symptoms appear suggestive of miliary or meningeal tuberculosis. When generalized miliary tuberculosis is suspected, bone marrow studies are essential for accurate diagnosis, just as it is necessary to find tubercle bacilli in spinal fluid to be sure meningitis is tuberculous. In fact, these acute clinical forms must be kept in mind among reactors in all ages of life. If these conditions develop, there is no time to temporize before instituting chemotherapy.

If the individual is in early childhood, one must watch for extrathoracic lesions, particularly those of bones and joints, and especially the spine, hip and knee joints. Only rarely does chronic pulmonary tuberculosis develop in children. Among individuals approaching adolescence or who are in later periods of life, including old age, the lungs must be examined periodically. Throughout adulthood, 10 to 15 per cent of clinical tuberculosis develops extrathoracically.

Inasmuch as 85 to 90 per cent of clinical tuberculosis develops in the lungs of adults, it is important that every adult tuberculin reactor be alerted to the necessity of periodic examinations. However, these should always include but never be limited to x-ray inspection of the chest.

By x-ray film inspection we are able to detect chronic gross clinical lesions earlier in their evolution than by any other phase of examination. These chronic lesions usually evolve slowly so that six to twelve months intervals between examinations are nearly always adequate. Among those persons in whom such lesions are destined to evolve, they can often be found by the shadows they cast long before symptoms appear and before they are contagious. As yet, we have no method of preventing such lesions from evolving in a considerable percentage of infected persons and, obviously, our only recourse is to find them as early as possible. When found in the early stage of their evolution the majority of them can be treated successfully with far less inconvenience and expense to the patient and society than those which are permitted to become extensive. Moreover, most early lesions can be prevented from becoming contagious.

There is one group of pulmonary tuberculous

lesions which should always be mentioned to tuberculin reactors who are being examined periodically. It consists of acute, exudative disease which, in reality, is tuberculous pneumonia. Such lesions may be plainly in evidence on x-ray film days or weeks after the chest appeared entirely clear. They are usually due to bronchogenic spread of tubercle bacilli. Apparently they occur much less frequently than chronic lesions and often result in symptoms soon after they appear. Therefore, every adult tuberculin reactor who is being examined periodically should be told that if any symptom develops, he should report at once rather than wait for the next scheduled examination. Persons with such disease may have tubercle bacilli in the sputum much earlier than those with chronic lesions.

Many physicians and hospitals are now making routine x-ray film inspections of the chests of all persons, regardless of the cause for which examination is requested or for which they are admitted. This, together with the mass photofluorographic surveys that are being conducted in so many places, is bringing to light a good many shadow-casting lesions previously unsuspected. These are due to a wide variety of causes. Inasmuch as x-ray shadows are never pathognomonic, the only function of the initial x-ray film inspection is to determine that gross lesions are present. It then becomes the duty of the clinician, the laboratorian, the roentgenologist, and often the bronchoscopist, working as a team, to determine etiology. This may be a simple task, or it may be time-consuming and laborious. Occasionally it is impossible.

There are two procedures which should supersede all others:

1. Administration of specific tests such as tuberculin and fungus antigens. If the individual is not seriously ill, the absence of a tuberculin reaction practically rules out tuberculosis. If a reaction is present, it does not determine with certainty that the lesion in question is tuberculous, although it may be. It indicates that tuberculous lesions are present, but the one under investigation may still be nontuberculous.

2. If sputum is present, it should be examined for pathogens, including malignant cells. If none is found which may be responsible or there is no sputum, gastric washings should be subjected to the same laboratory examination as sputum. If superficial lesions or enlarged lymph nodes are present, biopsy should be done for histological changes and bacteriological determinations.

When sputum and gastric washings are unrevealing and a lesion appears sufficiently significant, bronchoscopy is next indicated. The bronchoscopist looks for lesions involving the mucosa of the trachea and bronchi. He determines whether exudate is exuding from one or more ramifications. He looks for obstructions which may be caused by foreign bodies, mucus plugs, adenomata, malignant growths, as well as evidence of extrinsic pressure. If mucosal lesions are present or intrinsic obstructions are seen, material is removed for biopsy and bacteriological and pathological study. If no exudate or other abnormality is seen, the bronchoscopist introduces small amounts of normal saline solution and aspirates it for bacteriological and cytological determinations. He may then introduce iodized oil, after which the roentgenologist makes bronchograms.

Obviously, with most modern equipment the bronchoscopist is unable to inspect beyond the larger bronchial ramifications. Therefore, when lesions lie peripheral to his domain and no material is available for laboratory study, bronchograms may reveal partial or complete obstruction in smaller bronchial ramifications. Whether or not such evidence of obstruction is found in some cases, particularly those in the cancer age, thoracotomy is necessary to arrive at a diagnosis. If material removed in this manner is not found to be malignant or tuberculous, various other organisms, including fungi, should be sought. Chemical analyses may also be necessary for such substances as beryllium.

With all these diagnostic refinements, we are still unable to make a specific diagnosis in occasional lesions. Even at necropsy, microscopic, bacteriological and chemical tests sometimes fail. Many shadow-casting lesions found by routine x-ray chest film inspection are of no present clinical significance. They have long since been brought under control by the body's defense mechanism. Nevertheless, the physician should investigate every lesion to be sure that those which are significant are detected and do not go unattended.

The Use of Oral and Topical Calcium Preparations in Pruritus

A Preliminary Report

By W. T. Kruse, M.D.
Grand Rapids, Michigan

THE TREATMENT of dermatologic conditions often poses interesting therapeutic problems to the physician. Treatment cannot always be directed at the etiology since this is often undetermined. For this reason, empirical therapeutic approaches have been developed in an effort to treat some of these dermatologic conditions successfully. One of the problems involved in these conditions is that there are many aspects which must be considered in therapy. The etiology must be controlled; the emotional factor must be properly handled; the symptoms, *per se,* must be treated in order to alleviate the discomfort if the condition itself cannot be readily controlled.

Pruritus is one of the most unpleasant symptoms that may develop during or in association with many dermatologic conditions. The treatment of pruritus in these disorders often taxes the physician's therapeutic ingenuity. It is in some cases the easiest symptom to alleviate, and in the next, the most perplexing and difficult. What is good for one patient may increase the severity of the pruritus in another.

Among the preparations found beneficial for the control of pruritus can be listed those which contain calcium. It has been found that the calcium ion administered parenterally, will bring about relief in a majority of patients. Reports on the use of topical calcium have been sparse. This report presents the use of a combination of oral and topical* forms, the oral material being Neo-Calglucon Syrup—a highly concentrated preparation.

The use of calcium in dermatology is primarily empirical. However, a review of the basic physiology involved may explain some of the rationale for the use of this material to control various symptoms found in dermatologic disorders. Best and Taylor,[1] in a review of calcium metabolism, point out that this mineral is a constituent of all animal fluids and tissues, constituting about 2 per cent of the weight of the adult body, most of which is contained in the skeleton. It plays a role in blood coagulation, bone formation, maintenance of normal neuromuscular excitability, cardiac rhythmicity, milk production and membrane permeability. The chlorides of calcium and magnesium decrease membrane permeability, so that a change in blood calcium will affect fluid balance. The amount of edema in skin conditions may therefore, in part, be related to the amount of calcium present. It has been shown many times that depression of calcium will produce convulsions. Since, in tetany, calcium concentration in the tissues is unaffected, it appears that the neuromuscular excitability results from calcium imbalance between ionic calcium in the fluids within the tissue cells. From a review of calcium metabolism it can be concluded that therapeutic administration of this ion would be indicated to control neuromuscular excitation and fluid imbalance stemming from improper blood calcium levels.

The use of calcium in allergic diseases is widely controversial. There is no doubt of its effectiveness in controlling angioneurotic-edema and other similar conditions. Cantarow[2] showed the rapid effects of calcium upon glottic edema and vasomotor rhinitis. Tobias[4] reported that calcium ointment is of value in selected cases of subacute and chronic types of contact dermatitis, atopic eczema and localized neurodermatitis. Pruritus, associated with such conditions, was definitely controlled with a return of the affected parts to normal. The Schoch[3] letter of November, 1950, points out that L. Goldman observed that the same calcium ointment employed by Tobias was effective in treating the flexual type of atopic dermatitis. The product used by these men and also in this study is a water soluble base containing 10 per cent calcium gluconate with a pH of 5.5.

We employed both oral and topical calcium preparations in this series of cases. Oral calcium was administered in order to sustain calcium levels. The topical application was made in an effort to alter the calcium balance directly in the affected area.

Material

In this preliminary study, twenty patients with various pruritus dermatoses were treated with both topical calcium and oral calcium syrup. Seven patients had atopic eczema, two had nummular

*Calcium ointment is a research preparation of the Sandoz Pharmaceutical Company.

eczema, four had chronic infectious eczematoid dermatitis, two had chronic urticaria, two had chronic disseminated neurodermatitis, and three had contact dermatitis. In all, pruritus was the prominent and disturbing symptom. Some of the chronic cases which were relieved had continued for periods as short as six months and as long as ten years.

TABLE I. RESULTS IN TWENTY PATIENTS WITH VARIOUS PRURITIC DERMATOSIS

Disease	No. Patients	Good Relief from Pruritus	Disappearance of Lesions
Atopic Eczema	7	7	3
Chronic Infectious Eczematoid Dermatitis	4	2	0
Nummular Eczema	2	2	0
Chronic Urticaria	2	0	0
Chronic Disseminated Neurodermatitis	2	2	1
Contact Dermatitis	3	3	3
Totals	20	16(80%)	7(35%)

Method

Patients were instructed to apply the calcium ointment four or five times daily as required to control the itching. The experimental preparation contained 10 per cent calcium in a water dispersible organic base. To ascertain that the patients were not reporting imaginary beneficial effects, six patients were treated with the base alone. Two of these patients reported moderate relief. In cases where the ointment failed to alleviate the itching, the oral preparation—Neo-Calglucon Syrup—was used as a supplement, one tablespoonful, three to four times daily for adults.

Discussion

The best way to show those conditions which respond to this type of therapy is to discuss each individually. The action of calcium in relieving edema and nerve irritability is well demonstrated in our results. Although the skin lesions disappeared in only seven of the twenty cases, the important fact was that relief from the very annoying symptom of pruritus was obtained in 80 per cent of the cases.

Atopic Eczema—Seven cases in which pruritus was a very annoying symptom and which had lasted for a long time, responded well to this therapy. Only two of the patients did not show good response, but nevertheless, pruritus was diminished. In this particular condition, the original skin lesions also responded to the treatment in three of the seven cases. One of these was a case of hives. The hives also disappeared. Where fluid balance of the cells cannot be disturbed propitiously, then it can be postulated that topical calcium will be of benefit.

Nummular Eczema—The pruritus in these cases responded only moderately well while the lesions persisted.

Chronic Infectious Eczematoid Dermatitis—These cases of short duration responded to therapy. Two of the patients had excellent relief from the itching, but in none of the four cases treated did the lesions disappear.

Chronic Urticaria—Cases of three months' to one year's duration did not respond. Neither the itching nor the lesions improved under the therapy.

Disseminated Chronic Neurodermatitis—The itching in these cases responded extremely well and in one of the cases, the lesions disappeared. Here again, where nerve cell irritability and permeability is a factor, calcium seems particularly suitable as therapy.

Contact Dermatitis—The itching related to these cases responded to the therapy. Complete relief was obtained and, in addition, the lesions disappeared within 10 days to two weeks after start of therapy. Here the dermatitis was present for only one to two weeks in both patients, and both patients were taken away from the original offending contact agent.

The ointment used was found to be nonsensitizing in the twenty-six patients treated and was cosmetically acceptable to the patients.

In approximately one-half of the cases treated, the local calcium was augmented by oral calcium. It would appear that with the more recalcitrant cases, this augmentation is both necessary and helpful. The results obtained justify, in our opinion, the further use of calcium ointment with or without oral or intravenous calcium.

Summary

1. Twenty patients with various pruritic dermatoses were treated with calcium ointment with or without oral calcium.

2. Of the patients treated 80 per cent reported good relief of pruritus; 35 per cent showed dis-

(Continued on Page 1474)

The Use of an Antiseptic Synthetic Detergent for Local Hygiene in Pruritus Ani

By Herbert I. Kallet, M.D.
and
Lavelle Patrick Davlin, M.D.
Detroit, Michigan

THERE ARE a number of perianal dermatoses, usually characterized by itching, which have been grouped under the non-specific heading of pruritus ani. As with the other diseases of obscure origin, a variety of therapeutic modalities has been employed. These measures include the use of numerous ointments and applications having protective, anesthetic, antibacterial, fungicidal or antihistaminic properties; the injection under the perianal skin of anesthetic solutions with prolonged action, dilute hydrochloric acid or alcohol; superficial radiation; dietetic régimes; psychotherapy; tattooing; and in chronic intractable cases which present profound and irreversible skin changes, some type of definitive surgery.[1] Most writers also emphasize the importance of local hygiene, but no effective or practical hygienic agents have up to now been available. During the past seven months the authors have employed an antiseptic synthetic detergent, pHisoHex,® with gratifying response.

Whatever the initiating factor in the production of perianal irritation, the skin becomes increasingly inflamed by the presence of fecal material, mucus and other secretions. The serous ooze from the cracks and erosions which are so often present, tends to create a sticky matrix to which bits of feces and dried mucus adhere. This tenacious film gives rise to an uncomfortable and itching sensation. The groundwork is laid for secondary infections with bacteria, monilia and other fungi. The various ointments and creams which are prescribed or self-administered produce further irritation and a feeling of stickiness which leads to additional scratching and traumatism of the affected parts. Cleansing with soap, even of the superfatted variety, and the mechanical rubbing involved, seems to exaggerate rather than to alleviate the symptoms. Water alone does not adequately remove the detritus.

pHisoHex®, which is pHisoderm containing 3 per cent hexachlorophene,* is used as a surgical scrubbing agent in both the hospitals with which the writers are connected. It is a bland, nonirritating bactericidal and bacteriostatic detergent which has a pH value of 5.5 which corresponds to that of normal skin.[2,3] It suds readily with a minimum of water, and its surface activity is estimated to be about 40% greater than that of soap.[4] Theoretically, is seemed well adapted for perianal hygiene, as a soap replacing agent which might rid the parts of adhering foreign material, lessen secondary bacterial or fungus development, at the same time preserving the normal pH of the skin. Accordingly, a small group of patients having perianal itching was selected and instructed to employ this preparation as a local cleansing agent. The use of soap and all medication was interdicted. The relief obtained was so satisfactory that the study was continued.

The following technique has been found effective. Bathing is recommended once daily. Because of the tendency to nocturnal itching, if practical, the bath is taken at bedtime. Water is drawn into the tub and the buttocks immersed until wet. The patient then stands and squeezes on to the palm of one hand several cubic centimeters of the soap replacement which is worked up with water until suds begin to form. These suds are then transferred to the perianal region and the area gently but thoroughly washed. Sitting back in the tub serves to rinse off any remaining detergent. Emphasis is given that only one lathering should be done at each bath to avoid over-treatment. While drying, the towel should be used by patting as if it were a blotter, and care taken not to rub the irritated parts. This method of perineal hygiene should be continued indefinitely.

In those persons who are accustomed to a shower, similar instructions are given with the added caution that the rinsing should be done with especial care. It is important to give detailed directions. In spite of careful exposition of the technique, some patients have applied the detergent cream on dry skin or have used it as an ointment.

Thus far, forty-five patients have used this routine. Care was taken to select only those cases in which it was felt that improper hygiene was a primary or secondary factor in their pruritus. Although many had had symptoms for long periods of time (one instance twenty-five years), no more

*Sodium octylphenoxyethoxyethyl ether sulfonate with 3 per cent (2 hydroxy-3,5,6-trichlorophenyl) methane.

than moderate skin changes had taken place. Patients presenting pathological conditions such as vaginal discharges, rectal fistulae, mucosal prolapse, protruding hemorrhoids, anal stenosis, chronic anal fissures and the like, were purposely omitted from the study. Also, intractable cases of pruritus ani in which there were huge skin tags, chronic anal ulcers and marked lichenification of the skin, were not included.

The response of this group was surprisingly gratifying. Most of the patients reported a welcome feeling of cleanliness and an early diminution in the amount of itching. Physical examination demonstrated lessening of the inflammation and in many instances a complete resolution of the skin to normal. The following observations are typical.

M.A.L., a white restaurant owner, aged sixty-two, complained of intractable perianal itching for five years. He had been treated with many therapeutic agents including anesthetic ointments, subcutaneous injections of anesthetic drugs and superficial x-ray therapy. None of these procedures had given more than temporary relief. Bathing in the prescribed manner was begun November 1, 1951. Itching diminished within twenty-four hours and gradually ceased in the next few days. Relief has continued to date. While the time involved is brief, the early and complete improvement has been typical of the group.

Perhaps the most spectacular response was that of B. M. R., a fifty-year-old physician who had been observed with pruritus ani over a period of twenty-five years. Treatment by various local applications had been in the most part disappointing. On many examinations, the perianal skin was found moist, fissured and macerated. Tag formation and lichenification, which would indicate surgery, had never been present. Perianal hygiene by soap replacement was started June 12, 1951, and brought about a cessation of itching within a few days. The régime has been continued daily since that time, and in the seven months which have elapsed there has been no return of symptoms. At a recent examination the perianal skin appeared normal.

Mrs. L. McC., aged forty-five, was referred by her gynecologist with a history of vulvar itching dating back to 1947. There was concomitant itching about the anus. Smears had shown the presence of trichomonads, and she had been given several courses of anti-trichomonad therapy. The perianal itching persisted, however, and the process extended to the vulva on both sides. Examination demonstrated a reddened and thickened perianal skin with redness extending to both labia majora. Detergent baths were prescribed October 16, 1951. Both the perianal and vulvar itching disappeared within a few days and there has been no recurrence.

Dr. M. H., an optometrist, aged thirty-five, was referred November 7, 1951, because of intractable itching and irritation about the anus of eight months standing. He had used many local preparations, including several antibiotic ointments. Examination demonstrated a raw, irritated, moist perianal skin with many superficial erosions. Within forty-eight hours after institution of the soap replacement method, itching and burning had ceased. The moisture about the perianal region was much reduced. On November 14, 1951, examination showed the perianal skin to be normal in appearance.

The following case illustrates the untoward effect by over-treatment with the detergent. L. McC., an electrical operator, aged forty-seven, first reported for examination September 19, 1951, with a history of perianal itching of eight months' duration. Examination showed the skin about the anus moist and reddened, with numerous small erosions. He was advised to use the detergent bathing technique as outlined above. Detailed instructions were given as to the method of application. A few days later he reported that he had obtained considerable relief. On October 8, 1951, there was a return of irritation. Questioning brought out that he was applying the soap replacement after each bowel movement with a wet cloth several times a day. Again he was asked to follow the directions explicitly. This he did for several weeks and was symptom-free. Again he reported with a flare-up of the irritation. This time he admitted applying the detergent with wet toilet tissue on dry skin after bowel movements.

It must be emphasized that the detergent baths are recommended only as an effective and practical means of obtaining local hygiene. When improper cleansing of this area is a primary or secondary factor in pruritus ani, the routine described above may be found helpful. Because of the short period of time (seven months) since the authors have begun this study, no conclusions as to the permanence of the benefit can be made. Nonetheless, the pa-

(Continued on Page 1489)

Fractures of the Upper Extremity

By Robert J. Bannow, M.D.
Pontiac, Michigan

THE PURPOSE of this paper is to present for your consideration, several fractures commonly seen in the upper extremity, pointing out common errors in management, and suggesting methods of treatment which we have found satisfactory.

The first type of fracture I should like to mention is that of the so-called baseball or mallet finger. This is a fracture commonly encountered among athletes, particularly baseball players, and occasionally in industry, where a blow may be struck upon the extended distal phalanx. The mechanism of such a fracture is that of a blow inducing passive forced flexion of the distal phalanx, while the extensor tendon is firmly contracting to prevent this motion. The distal insertion of the long extensor tendon may be avulsed without carrying with it a piece of bone. On the other hand, a fragment of bone may be avulsed at the time of injury. A characteristic dropping of the distal phalanx into an attitude of partial flexion is seen. Passive extension is normal, but the joint cannot be actively extended. The unopposed pull of the long flexor tendon produces a 60 to 80 degree flexion deformity and the typical baseball finger configuration. A secondary disability often develops at the proximal interphalangeal joint, which may prove even more incapacitating than the deformity at the terminal joint. This consists of a hyperextension deformity at the proximal interphalangeal joint level, due to laxity of the extensor tendon sheath.

Better results are obtained in treatment, when a small portion of bone has been avulsed and is brought into apposition and securely held long enough for firm healing to occur. Generally speaking, less satisfactory results may be anticipated when the tendon has been torn without carrying with it a small fragment of bone.

The common practice of applying a tongue blade splint with the proximal interphalangeal and distal joints in extension is not satisfactory. Watson-Jones, Bunnell, and others have repeatedly stressed the necessity for splinting fingers in flexion at all times, and state definitely that there are *no* indications for splinting the finger in extension at any time.

We have employed plaster fixation of the finger in the following manner: With a plaster-of-Paris application, the distal interphalangeal joint is held in hyperextension while the intermediate interphalangeal joint is maintained in 90 degrees of flexion. Two tabs used for tying about the wrist serve to steady the cast and keep it from gliding upon the finger. The technique for application of the cast is similar to that for applying a club-foot type of cast in that the skin is cleansed carefully and tincture of benzoin is painted over the finger. Thereafter, a layer of outing flannel is applied. Over this, the plaster-of-Paris is molded. The finger should be maintained in this type of fixation for a period of six weeks to permit consolidation of the bone fragment to the distal phalanx.

A second type of fracture to which I should like to call attention, is that of an oblique fracture of a phalanx. This fracture occurs very frequently and there is often difficulty in securing anatomical reduction and reposition of the fragments. In such a fracture there is a tendency towards overriding of the fragments and if the point of one fragment is very near to the joint it may interfere with joint function in the future. All too frequently, we have had the experience of seeing these fractures slip out of position with a resulting crippling deformity when healed in malposition. Therefore, our current practice is to treat these fractures with traction applied as a *preventative* measure to keep the fracture from slipping into an unfavorable position.

The application of traction to the finger is accomplished by an adhesive type of covering. The finger is painted with collodion, followed by the application of a one-half inch strip of webbing material which is then again painted with collodion. Traction may then be applied, consisting of a rather substantial pull through rubber bands attached to a wire incorporated in a plaster-of-Paris cast. The remaining fingers of the hand are left free to be mobilized and exercised, and, after a period of three weeks, it is possible to remove the traction and allow restricted use of the hand, including the affected finger. It is far better to anticipate the prospect of this fracture slipping out of position than to deal with it once

Presented at the Sixth Annual Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, March 12, 1952.

it has gone into a position of deformity. It is not necessary to apply skeletal traction for this particular kind of fracture.

A third type of fracture is that of the metacarpals in the palm. A transverse fracture of a metacarpal in which some lateral displacement has occurred can be controlled by the use of a banjo-type of splint with adhesive traction to the finger.

This particular fracture demonstrated what, to our mind, is a very important point in the management of all fractures of the hand, particularly with reference to the metacarpals and phalanges. Local infiltration and manipulative reduction is seldom very satisfactory, and traction applied with the aim of obtaining a satisfactory reduction *in time* has not been satisfactory. It is our strong feeling that manipulative reduction should be carried out under general anesthesia or brachial block anesthesia, so that accurate reposition of the fragments is obtained very early. After this, it is far less important as to what method of fixation is employed, as the results, generally speaking, will be satisfactory if an early anatomical reduction is obtained.

In one of our cases in which there had been persistent lateral displacement and the patient was not seen by the orthopedic surgeon until some ten or fifteen days following the fracture, it was impossible to do very much except reduce the fracture by open methods. This was declined by the patient and, as a result, he has a weakened grip in the hand with a nodule which he feels and which is palpable in the middle portion of the palm of the hand. It exerts a constant factor of disability from which he will probably not fully recover. This deformity is particularly disabling to workmen who must grasp tools firmly in the hand.

Two fractures of the base of the thumb metacarpal are of interest. The first type is that of the so-called Bennett's fracture. This should more properly be called a "Bennett's fracture dislocation." There is a triangular fragment of bone which remains in its normal position while the metacarpal slides downward along the surface of the trapezium. The *only* method by which this fracture may be maintained in reduction is by traction. In this instance, skeletal traction is applied. Our method of doing this is that of insertion of a small Kirschner wire through the distal phalanx of the thumb. The proper site of insertion can be easily determined by placing the wire in line with the base of the thumb nail and two-thirds the distance between the flexor and extensor surfaces of the finger. It may be drilled through the bone satisfactorily under local anesthesia if desired. Brachial block anesthesia may be preferable in view of the foregoing remarks pertaining to other fractures about the hand. The Kirschner wire may be inserted under the same anesthetic. It is done under sterile precautions and may be an out-patient procedure if desired. Following the application of a plaster-of-Paris cast to the forearm, incorporating a piece of coat-hanger wire for traction, the Kirschner wire is bent into a traction bow apparatus and attached to the coat-hanger wire by means of a rubber band.

A device, used by us, to hold the wire in place is made by wrapping a piece of sterile cotton fiber around the Kirschner wire at the point of skin insertion and touching it with a drop of collodion. When this solidifies, it constitutes a "bead" which will immobilize the wire in the finger at this point, and prevent lateral slippage. No dressing is required in addition to this treatment of the Kirschner wire. Traction is maintained for a period of at least three weeks. The position of the thumb is the same as when it is used to grasp the arrow in shooting with a bow and arrow.

The second type of fracture involving the base of the first metacarpal occurs through the base of the shaft and not through the articular surface. In this instance, there is likely to be lateral angulation. The general contour of the fracture is quite unsatisfactory, although the functional impairment is not as great, should the fracture heal in a moderate position of angulation. The fracture habitually lies within one-half inch of the joint. There is no joint injury. After reduction, the position of the fragments is stable and there is little or no difficulty in preventing displacement. Continuous traction is seldom necessary. The treatment of this fracture is, therefore, in marked contrast to that of the Bennett's fracture dislocation, where reduction is unstable, continuous traction is essential, and the penalty of imperfect reduction is a painful stiff joint and a serious disability.

Another upper extremity fracture of interest occurred in a man approximately forty years of age. An injury of the carpal scaphoid bone was seven months old when an x-ray examination was made. There was a fracture through the carpal scaphoid bone with rotation and displacement of the proxi-

mal fragment. In this position, no one could anticipate healing of any kind and disability should be expected. It is probable that this fracture was not completely recognized for its true extent at the time of injury. It is our habit to take three views of the wrist at the time of suspected injury to the carpal scaphoid bone. These consist of an antero-posterior, a lateral and a three-quarters view of the bone. A fracture line can usually be observed in one or another of these views, particularly when compared with similar views made of the opposite wrist. In the event of suspected fracture, although the x-rays do not reveal it upon initial examination, the wrist may be splinted in plaster or a conventional splint for a period of about ten days. At the end of ten days re-examination by x-ray is done. If a fracture is present, demineralization along the line of fracture will have occurred in this time and one can then be more certain of the existence of the fracture.

In the patient mentioned there was also a displacement of the carpo-lunate bone. This dislocation may exist without associated fracture but is more common in the presence of a fracture of the carpal scaphoid. Of the two injuries to this man's wrist, the dislocation of the carpal lunate may prove to be the more serious one over a period of time in view of the impingement of the median nerve at the wrist. This ultimately results in pain, weakness, and a median nerve palsy in the hand.

When seen initially, a preliminary period of immobilization of the carpal scaphoid fracture should be carried out, anticipating some degree of bony healing. After a period of about three months, one can decide by the progress of healing whether or not other measures may be necessary to secure solid healing. These methods include bone graft operation, excision of one or both fragments of the bone, and arthrodesis of the wrist.

A very difficult type of fracture encountered in the upper extremity is that of the forearm with consequences at the elbow joint. Monteggia described a fracture of the upper shaft of the ulna with dislocation of the radial head in 1814. It has taken more than a century to find a treatment for this injury. No fracture presents so many problems and no treatment is characterized by more general failure. The special complications are mal-union of the fracture of the ulna, non-union of the fracture of the ulna, unreduced dislocation of the head of the radius, stiffness and arthritis of the elbow joint, myositis ossificans around the radial head, and ankylosis of the radio-ulnar joint. Occasionally, cross-union at the level of the fracture between the ulnar and radial shafts occurs. Watson-Jones, in his book entitled Fractures and Joint Injuries, states that 90 per cent of his cases has shown some evidence of permanent disability.

Special care must be taken in the interpretation of the x-rays to recognize that a fracture of the upper shaft of the ulna is *seldom* an *isolated* injury. It is nearly always associated with a dislocation of the head of the radius and avulsion or rupture of the orbicular ligament. A typical patient seen in our practice was a fifty-five-year-old woman. Reduction of the fractured ulna was accomplished and maintained with a stainless steel plate of the usual variety. The end result, several months after the application of the plate and screws, was recurrence of disability at the elbow joint with forward displacement of the head of the radius. The disability was rather slight. The patient had a full range of pronation and supination and lacked only the last 15 degrees of complete flexion of the elbow, while extension was complete. In this case, one would not consider further intervention. However, more often than not, a great deal of disability may result and it is recommended that special attention be paid to this type of fracture in the very beginning.

Sometimes it is possible to reconstruct the annular ligament at the elbow at the time of open reduction of the ulna. We have a case in which this was satisfactorily performed on a teen-aged boy who is an athlete in school. He has resumed normal active motion of this elbow and has participated and excelled in basketball, football, and track following repair of the annular ligament. A normal range of motion was possible and there was excellent power and stability.

One of our patients had an epiphyseal injury to the elbow. The initial x-ray was made in 1942 and demonstrated a severe supracondylar type of fracture with comminution and displacement. During the interval between 1942 and 1946 difficulty had developed with an angulation type of deformity, limited flexion and extension, and irritation of the ulnar nerve at the elbow. Transposition of the ulnar nerve anteriorly was done in order to overcome an ulnar neuritis of mechanical origin.

On another of our patients a corrective wedge osteotomy was done above the elbow joint, in order to bring the axis of flexion into a more nearly normal plane. When the patient was last seen the elbow had about 90 per cent of the normal range of flexion and extension, and normal pronation and supination. There was some shortening of the arm, but function was good and the deformity not very noticeable.

A typical supracondylar fracture of the humerus occurred in a boy aged six. There was a severe displacement with marked swelling of the forearm and elbow and we properly anticipated a Volkmann's ischemic contracture. This particular fracture was seen within an hour of the time of injury and an early manipulative reduction was done. In this instance, a small rotational deformity could not be completely corrected, but in view of the comparatively good control over a very difficult fracture, it was decided to leave the arm in this position. The functional result has been excellent and the youngster, at the time of this writing, has regained approximately 85 per cent of the normal range of flexion and extension of the elbow joint and has normal pronation and supination of the forearm. With further passing of time and advancing growth of the distal humeral epiphysis, a better result should follow.

I should like to mention at this time, the use of traction in control of such a deformity as this. Where the swelling is severe it is often unwise to attempt a manipulative reduction and add insult to injury. Very often, if manipulative attempts are carried and acute flexion of the elbow is performed with a plaster-of-Paris cast application, the embarrassment to the circulation is such that a Volkmann's contracture will ensue. At least the risks are very high. The price of this error is extremely high in functional impairment in the future. An alternative method has been presented in which traction is exerted upon the extended arm, with weights and pulleys so disposed as to cause a downward pull upon the arm along the axis of the humerus, while a counter-traction weight is applied just above the elbow to pull the proximal fragment posteriorly in relation to the distal fragment. This type of traction accomplishes two things. Namely, the arm is left in extended position and circulation is less embarrassed than by acute flexion of the elbow. Secondly, satisfactory reduction can often be accomplished in this manner and after early callus formation about the fracture, the elbow may be flexed to any desired position and maintained in plaster until the healing is complete.

Fractures of the head of the radius occur relatively frequently. In dealing with these fractures, one should remember that the optimum time for operation is within the first ten days of injury. The surgeon must decide early whether or not an operation is necessary. He is not at liberty to defer the question for several months in order to see what would happen. Delayed excision of the radial head seldom improves the range of extension movement. Some writers have stated that it is inadvisable to perform the operation before the third or fourth week because early operations may be followed by ossification of the hematoma. This complication does not occur if the operation is performed properly. Excision of the whole head appears to be preferable from the standpoint of satisfactory end result rather than removal of a marginal section of the fracture.

An example of a fracture of the shaft of the humerus is given here in order to outline the current popular method of internal fixation using a Rush intramedullary nail. A transverse type of fracture with angulation and displacement was treated by making a short incision over the head of the humerus at the level of the greater tuberosity and inserting a Rush intramedullary nail in the axis of the humerus. Manipulation of the fracture was carried out under fluoroscopic control and the Rush nail was driven to its complete depth into the distal fragment.

It is not always possible to secure satisfactory manipulative reduction at the time of insertion of the Rush nail, and accordingly, a separate incision is often required over the point of fracture to visualize the fracture and the protruding portion of the nail as it is being driven into the proximal fragment. The fragments may then be reduced by manipulative methods under direct vision and the Rush nail can be driven to its complete distance. No form of external immobilization is employed, although a sling is commonly given. Early active motions of the arm, wrist, forearm and hand are encouraged and the disability from limitation of flexibility is minimal. All of these fractures treated as above have healed satisfactorily in the usual time. Sometimes, it is necessary to remove the Rush nail at a later date, although if the proximal portion of the

nail is buried in the notch between the head of the humerus and the greater tuberosity, it does not interfere with joint function and may not require removal.

A severe fracture involving the head and neck of the humerus can often be treated satisfactorily in a hanging type of cast. Satisfactory functional results may be obtained even though an anatomical reduction is not secured.

Occasionally, one will encounter a type of fracture in which there has been such marked comminution of the head or such severe displacement of the capital fragments into the commonly described position of dislocation of the shoulder, that surgical removal of the head becomes necessary. We have excised the head of the humerus in several cases and the end results have been quite satisfactory. From the standpoint of elimination of pain, most of them have been good, although stability is often sacrificed. If care is taken to preserve the attachments of the rotator muscles into the proximal portion of the shaft of the humerus, excellent control of internal and external rotation is frequently possible, although the power of abduction of the shoulder is usually weak.

Another type of injury about the shoulder area which has been quite common consists of an acromio-clavicular joint separation. This may involve the acromio-clavicular joint itself, and may, in its more severe form, involve the conoid and trapezoid ligaments. In the early stages of the suspected diagnosis, a comparative anteroposterior x-ray should be made with a weight of ten pounds in each hand. This will readily reveal any loss of stability of the acromio-clavicular joint. If the separation is mild and the injury is acute, a satisfactory taping of the joint may be carried out.

If the separation at the time is severe or if later the result of an old, acromio-clavicular separation is seen, selection of the type of repair is often difficult. Repair of the conoid and trapezoid ligaments is difficult. Wiring of the acromio-clavicular joint is mentioned only to condemn the procedure, since it will eliminate the rotational motion of the clavicle in its long axis at the acromio-clavicular joint and prevent certain overhead motions of the shoulder. One method of treating this condition is that of excision of the acromio-clavicular joint. In this instance, approximately 1 to 1.5 inches of the distal end of the clavicle is resected. The procedure has much to recommend it from the standpoint of short disability and hospital stay and early use of the arm.

One of our patients had an excision of the acromio-clavicular joint and, within ten days of the operation, was beginning to use his arm for feeding and dressing himself. Within six weeks he was using it to pursue his usual occupation in one of the automobile plants in the city. In ten weeks, he had resumed activities including bowling and states that his score is better now than it was prior to the time of injury to his shoulder.

The final type of fracture I should like to mention is that of the clavicle with particular reference to complications. We have had two experiences with this type of injury which apparently are somewhat unique. The first of our patients, a woman aged thirty-eight years, was the victim of a freak accident in which an automobile tore through the side of her home while she was sleeping, knocking her out of bed and across the room. She sustained multiple injuries including a fracture of the clavicle. Delayed union followed the conventional method of manipulation and immobilization. In addition to this, it was discovered on re-examination that the proximal portion of the clavicle had become dislocated at the sterno-clavicular joint. It was decided to attempt an open reduction of the clavicle and to provide some type of internal fascial sling repair of the sterno-clavicular joint. At the time of surgery, it became apparent that in order to secure apposition of the bone ends a further resection of bone would be necessary, causing foreshortening of the shoulder girdle. It was decided, in view of the presence of both of the above lesions, that excision of the entire clavicle should be carried out. This was subsequently done. The arm was immobilized in a light Velpeau type of bandage immediately following surgery. The sutures were removed on the tenth postoperative day, and the wound was healed satisfactorily. Early flexibility exercises of the shoulder were instituted on the fifteenth day, and the patient continued to develop increasing flexibility and power in the shoulder. She is now capable of full range of flexibility in the arm in respect to all essential functions, including reaching in the overhead position. There is a little weakness of the shoulder in the extreme overhead position, but otherwise there is no limitation of flexibility and there is no spontaneous pain or other disability.

(Continued on Page 1457)

Rural Practice Can Be Fun

By John R. Rodger, M.D.

Bellaire, Michigan

"CAN I practice good medicine there? Can I make a decent living there? Will I enjoy making my home there?" These are the three questions which every medical student and intern eventually asks himself. Let us relate these three questions to rural practice, but first clear the decks of some hazy ideas about general practice as a whole and rural practice in particular.

The medical student or intern contemplating general practice may make an error in either of two directions. First, he may think of general practice as too comprehensive and therefore fear it if he doesn't excel in all the branches of medicine. Only a general practitioner in an extremely isolated area would find himself in such a situation. Second, he may view the field of general practitioner as too limited, thinking he will turn out to be just a glorified first-aid man or treater-of-minor-illnesses, with anything interesting or complicated going to the specialist.

Neither of the above views is correct. Medicine is a teamwork proposition that requires both the general practitioners and the specialists working with, not against, each other. An adequately trained general practitioner can do approximately 95% of the work which comes his way in obstetrics, and 85% of that in general medicine, pediatrics, and surgical diagnosis. With an average of twenty to forty patients a day I refer from one to five of these to a specialist.

The man deciding against general practice may do so partly on the grounds that he thinks such a practice will cause him to miss a lot of interesting professional experiences, such as the roentgenologist discovering a parathyroid tumor from a study of areas of decreased density in a tibia, or the surgeon finding an acute Meckel's diverticulum, or the pediatrician picking up a pulmonary stenosis. But consider what these different specialist miss! No x-ray man ever has the chance to diagnose an acute Meckel's diverticulum; no surgeon has the fun of catching on to the presence of a parathyroid tumor from an x-ray study of a tibia; no chest surgeon operating upon a congenital heart was ever the first to pick up the case on a routine examination; no pediatrician delivers the babies he takes care of; and no obstetrician sees his babies after he has tied the cord! There are no fields more limited by hard and fast boundaries than the specialties. Depth of knowledge in specialization at times seems to be in direct ratio to loss of surface area. Conversely, breadth of surface area does not have to mean shallowness of knowledge unless a man is inept or lazy.

Medical practice in rural areas today is as far distant from the old practice of yesteryear as is the modern car from the horse and buggy. People in rural areas have always deserved as good medical care as those in the cities, and they are now demanding it. The farmer won't operate his land with old-fashioned machinery, and he doesn't want the doctor to operate on his child on the kitchen table! When it comes to modern medical science, we don't have to sell the rural population a "bill of goods"; we only have to supply the medical care they want.

Professional Activities

Now to the first question, "Can you practice good medicine in the country?" My answer is a definite "Yes." No man in the country need go to seed professionally unless he so wills it through his own laziness. All areas have monthly county or district medical meetings, most of which are built up around scientific programs. Hospitals in the area have scientific programs at staff meetings. Many states now bring post-graduate education right out to a spot within 50 or 75 miles of the doctor. State and national medical meetings are always available. Your patients expect you to go to some of these, but if your area has only a few doctors, you and your colleagues should stagger your absences. Medical centers have their post-graduate courses and many M.D.s in rural areas are members of the Academy of General Practice, with it stimulating requirement for membership of at least 150 hours of post-graduate study every three years. Last but not least, there are your journals and books. You should find time to read them in your regular week's routine, but at least you can read them while waiting for that delivery or while on vacation. My summer's journals are usually read before an open fire during a September week in a cottage by the shore of Lake Michigan. Sometimes they are digested better that way!

EDITOR'S NOTE: This article is reprinted from the Journal of the Student American Medical Association, April, 1952, by request of the Executive Committee of the Council, because of the great general interest, and the excellence of the paper.

Specialists Available

Good practice also means the availability of consultants. Most smaller towns are grouped around a larger trading center town or small city. It is usually here that the largest hospital will be found. Around this hospital will invariably gravitate a growing number of specialists. In my section of Michigan, there are two such trading center cities. Sixteen years ago, both together could provide only four Board-certified specialists—now there are 24, with all major specialty groups represented except neurosurgery. The man contemplating specialization should remember that very frequently he will make a better living and enjoy life more in a small city than he would if he settled in a large urban area. In a few years, with the present stimulus of Federal matching funds for hospital construction, it will be an unusual trading center area which does not have adequate hospital facilities.

Medicine today depends greatly upon the help of the laboratory, and going to the country does not mean leaving the laboratory behind. Some of the more routine jobs you will do yourself! These include blood counts, urinalyses and sedimentation rates. Recently, an easy and short method of doing a blood sugar in the office has been evolved. Many state health department laboratories provide an excellent service for Kahns, Rh determinations, sputums, throat, stool and blood cultures, smears, widals, and guinea pig inoculations. The private lab in connection with your area hospital can do your blood chemistries, BMR and EKG studies, or cultures on which you want quick returns. Biopsies taken in the office can be sent to the best pathology lab available.

Necessary Equipment

You will need a certain amount of equipment beyond that of the man in urban practice. In addition to the bare essentials everyone needs, you should have a microscope, hemocytometer, splints, and sedimentation apparatus (a very usable and portable "micro" method for the latter is available). Sedimentation apparatus is of inestimable value in diagnosing and appraising both coronary and rheumatic fever cases. You should also have oxygen therapy equipment, with an E tank for the car, a BLB mask and a reduction valve for using with the larger garage tanks. If you have it, you will use oxygen even more than adrenalin. Optional office equipment to be added later if you so desire would be x-ray, diathermy, EKG and BMR apparatus.

In your car you should carry a fair-sized bag containing all the drugs usually needed in an emergency. You can't go ten miles out in the country and just leave a prescription. You should also carry home obstetrical equipment, oxygen equipment, a microscope if the call sounds like an acute abdominal emergency, a sedimentation outfit if it sounds like a coronary or if you are evaluating the convalescence of a youngster with rheumatic fever.

Transportation

If you live in the north country, you should have a reliable car with good heater, a warm light weight driving coat, warm mittens, a cap, and possibly snow-shoes for the semi-occasional time you have to get off on an unplowed road. In some areas of the country a jeep will save you time. When the neighbors see you bouncing across-country in a jeep with an oxygen tank, they won't know if it is the garage man coming to weld Pa's tractor, or the doctor coming to care for Grandma's cardiac asthma!

Finally, in the country there is a certain type of mental equipment which you will need. You should have an interest in people so that you will get to know as much as possible of the total background of your patients. This is very important today with the emphasis upon psychosomatic medicine, and something which is much easier to do in the country than in the city. In the country, you don't need a social service worker to dig out the picture of your patient's environment. You should also have a certain degree of self-assurance without being "cocky." There will be times when you must make some important decisions by yourself without the help of colleagues. Perhaps General Stonewall Jackson's advice to his younger officers is also good for us, "Never underestimate yourself in action, and never overestimate yourself in the official report."

Lower Expenses Help

Next, can you make a decent living in the country? Remember that your expenses to begin with are lower, and that there is a shorter waiting period before the money starts to come in. Many communities needing doctors are adopting the "Kansas plan" of financing office space and equipment for the young M.D. who cannot easily estab-

lish bank credit. The community becomes his bank and takes him on as a credit risk with no mortgage. Collection percentages invariably are better than they are in the city, "dead-beats" are fewer and don't float from doctor to doctor. In 16 years of practice in what the Michigan State Tax Commission rates as the sixth poorest county in this state, I have always collected from 90 to 98%, send out statements not over four times a year, and have never turned over an account to a collection agency! My experience is typical of that of hundreds of other men in rural areas.

A less ambitious retirement and insurance program is needed than would be true in the city. In terms of home maintenance, a $60-70,000 insurance program in a small town would have to be matched by one of at least $100-125,000 in the city. Don't forget that over a certain limit the inheritance tax takes a huge bite.

Build Your Own Office

If you decide to build an office rather than to rent, it is much easier to build exactly what you want if you are in a small town. Remember that rural people appreciate a neat, well-planned office just as much as city people do. I know a fine old doctor who, after practicing for fifty years in Chicago, partially retired but still maintained a limited practice in the country where he has vacationed for years. He built a beautifully panelled office as an addition to his cottage. When I remarked about it he said, "For fifty years I practiced in Chicago. I had to rent space and I never had the kind of an office I really wanted. Now, even though I practice comparatively little, I have the kind of office I've always wanted." He practiced in Chicago for fifty years before he had the kind of an office he wanted. I practiced in the country and waited five!

I know of no young doctor in rural practice who is not making a very decent living. Beyond a certain point, there is no incentive to roll up a large income, because the extra hours only help pay off a tiny crumb of the national debt! The extra work gives one a fine chance to have a coronary at forty-five to fifty; your widow will then put a nice stone over your grave, and your children will say, "How nice of the Pater to carry all that insurance so that we can go to college in style—but it's too bad we never got to see much of him!"

Life in a Small Town

Now we come to the third question, will you and your family enjoy living in a small town? Modern methods of communication have made the small town and the city much closer to each other than we sometimes realize. Good roads and modern cars bring you near the big city hospital, shopping center and concert hall. Young college graduates in other fields are going to the country in increasing numbers. In almost any small town, you will find a number of "kindred spirits."

In the country, there is less artificial living than is often found in the city. If you and your wife just have to have a certain amount of night life in urban "hot spots" every week, then the country may not be for you! However, there are other compensations not found in night clubs. For instance, you should be prepared in time to accept a certain degree of community leadership in whatever fields of activity you enjoy the most—health council, boy scouts, luncheon clubs, church, or school board. The community hopes you will be a leader, but a democratic one. The same goes for your wife. The community wants both of you to be neither garrulous nor aloof. People want you to become a part of the community and not be just outsiders.

Planned Vacations

In rural as in urban practice, don't forget your vacations. A perennially tired doctor is a poor one. The community will expect you to take a vacation just as it expects the teacher, the minister and the business man to do the same. The only thing it asks of you is that you will see to it that a colleague in your town or an adjoining one will be available for emergencies. We endeavor to take a two-week vacation for all the family when school is out in June. My wife and I take another week in the early fall. In addition, I take off from one to two weeks a year for state and national professional meetings, and another twelve to fifteen days scattered over the year for committee and other meetings in connection with organized medicine's activities.

To really enjoy rural life you must love the out-of-doors. Your enthusiasms may range over the fields of hunting, fishing, sailing, skiing, canoeing, sketching, picture-taking, hiking, or just driving over the countryside. In the city, we go to an art gallery to see a Rembrandt painting or a Grant Wood landscape. In the country, we learn to search in a patient's face for a little of what Rem-

brandt would have found if he could have seen it, and we can get our Grant Wood landscapes first hand instead of via a canvas!

The Intangible Things

I would not want to leave the impression that all is always sweetness and light in rural practice. Sometimes you have crotchety and heedless patients, just as in the city; many times you will be late to meals, just as in the city; family plans get upset at the last minute, just as in the city; you may battle blizzards, but in the city you will battle iced streets with considerably more personal hazard; you will get discouraged sometimes and wonder why you ever took up medicine at all—just as happens at times in the city. But by and large, the country presents no major disadvantages not also found in the city, omits no major advantages found only in the city, and provides many rich resources for living which are peculiarly its own.

The chief satisfactions of medicine, as in all of living, are the intangible ones. "The things which count the most are the things we can't count." There is no greater vocational satisfaction than the feeling that you "fit in," that you are needed and wanted.

Medicine encompasses both the fields of research, plus the bringing of the results of this research to sick patients. If you feel that the latter job is to be your chief role in medicine, then don't forget that relatively speaking, the rural areas of America need M.D.s more than the cities do. If you finally become convinced that in the country you can practice good medicine, make a decent living, find certain individual satisfactions in your work there, and if you and your wife want to give rural living at least a try, then come on!

FRACTURES OF THE UPPER EXTREMITY

(Continued from Page 1453)

Our second patient to undergo excision of the clavicle was a man aged twenty-eight years, who sustained a fracture of the clavicle as a youngster. This healed with a firm mass, oval in contour, in the region of the fracture. He had difficulty in the army carrying a pack upon his shoulder. Following discharge from the service, he had increasing disability with pain. He was unable to lie upon the affected side at night during sleep and, for several months prior to our initial examination, had a sensation of numbness in the arm. Examination revealed a large mass of calcareous material in the mid-portion of the clavicle. X-ray revealed a non-union of the fracture in the mid-portion. The cartilagenous mass of callus about the fracture was not visible in the initial x-rays. It was decided that open operation should be carried out. Again, it was discovered that when the mass of cartilaginous material at the bone ends was removed, not enough of the shaft of the clavicle remained to provide contact of the major surfaces. Rather than attempt a free bone graft to the fracture site, we decided to perform an excision of the clavicle. The incision was extended and the entire shaft of the clavicle was removed from the sterno-clavicular to the acromio-clavicular joint. The wound was repaired and healed uneventfully. The patient was discharged from the hospital in ten days. Early active and passive movements of the shoulder were carried out.

At this writing, the patient has developed a full range of flexibility in the shoulder with no symptoms referable to the shoulder itself. There is a slight depression cosmetically in the area of the clavicle and there appears to be some exaggerated motion of the shoulder girdle such as one might see in a congenital absence of the clavicle (cleido-cranial-dysostosis). At the last visit, he was performing vigorous manual duties, using his arm in his work as a rug cleaner where scrubbing motions of the arm were required. He no longer has any parasthesias in the forearm or hand and can use his arm normally for all purposes.

These two cases, in particular, are of great interest to us since they have demonstrated that one may resect a portion of the clavicle and even the entire bone without disability from a mechanical-functional viewpoint.

Michigan Clinical Institute

Sheraton-Cadillac Hotel, Detroit

Popular "Block System"

TIME	WEDNESDAY March 11, 1953	TIME	THURSDAY March 12, 1953	TIME	FRIDAY March 13, 1953
A.M. 8:30	Registration. Exhibits Open	A.M. 8:30	Registration. Exhibits Open	A.M. 8:30	Registration. Exhibits Open
	Four SURGICAL Subjects		*Four CANCER Subjects*		*Six HEART AND RHEUMATIC FEVER Subjects*
9:00	Everett N. Collins, M.D. Cleveland	9:00	Raymond W. Houde, M.D. New York City	9:00	Harold B. Houser, M.D. Warren A.F.B., Wyo.
9:30	Lester R. Dragstedt, M.D Chicago	9:30	Matthew H. Griswold, M.D. Hartford, Conn.	9:20	Harper K. Hellems, M.D. Detroit
10:00	Intermission to View Exhibits	10:00	Intermission to View Exhibits	9:40	Forest D. Dodrill, M.D. Detroit
11:00	Gaylord S. Bates, M.D. Detroit	11:00	*R. S. Sykes Lecture* Harold W. Dargeon, M.D. New York City	10:00	Intermission to View Exhibits
11:20	Robert S. Dinsmore, M.D Cleveland	11:30	James R. Driver, M.D. Cleveland	11:00	Edward M. Kline, M.D. Cleveland
P.M. 12:00	Discussion Conference *Leader* W. H. Huron, M.D.	P.M. 12:00	Discussion Conference *Leader* F. A. Coller, M.D. Ann Arbor	11:20	Robert A. Gerisch, M.D. Detroit
				11:40	William B. Kountz, M.D. St. Louis, Mo.
1:00	Luncheon	1:00	Luncheon	P.M. 12:00	Discussion Conference *Leader* E. D. Spalding, M.D. Detroit
	Six OB.-GYN.-PED. Subjects		*Seven SURGERY OF TRAUMA Subjects*		
2:00	Lester E. Bauer, M.D. Detroit	2:00	A. Jackson Day, M.D. Detroit	1:00	Luncheon
2:20	John M. Nokes, M.D. Charlottesville, Va.	2:20	Albert D. Ruedemann, M.D. Detroit		*Six INTERNAL MEDICINE Subjects*
2:50	Donald J. Barnes, M.D. Detroit	2:30	Joseph L. Posch, M.D. Detroit	2:00	William S. Reveno, M.D. Detroit
3:10	Intermission to View Exhibits	2:40	Elmer R. Jennings, M.D. Detroit	2:20	Winthrop N. Davey, M.D. Ann Arbor
4:10	Joseph C. Gemeroy, M.D Detroit		Discussion Period	2:40	Final Intermission to View Exhibits
4:30	Cleary N. Swanson, M.D Detroit	3:00	Intermission to View Exhibits	3:15	Abraham I. Braude, M.D. Ann Arbor
4:50	John S. Lundy, M.D. Rochester, Minn.	4:00	Prescott Jordan, Jr., M.D. Detroit	3:35	Carl B. Beeman, M.D. Grand Rapids
		4:15	Homer M. Smathers, M.D. Detroit	3:55	Henry A. Luce, M.D. Detroit
		4:30	George T. Aitken, M.D. Grand Rapids	4:15	Michael M. Dasco, M.D. New York City
		4:45	Discussion Period	4:45	End of Institute
6:30	Dinner Hour	6:30	Dinner Hour		
8:30	Public Meeting Atomic Energy		No Scientific Meeting Thursday Evening		

No Registration Fee for MSMS Members at Michigan Clinical Institute

Cancer Must be Detected Early— In Your Office

The fourth Annual Michigan Cancer Conference was held at East Lansing on October 9, 1952, and, as usual, was well attended by an attentive group of people interested in cancer control education. These conferences, originated by the Cancer Control Committee of our State Society and co-sponsored by the Michigan Department of Health and the Michigan Division of the American Cancer Society, are of distinct value in refreshing and stimulating the leaders of cancer control education throughout the state.

Two facts should stand out in our thinking about cancer control. First, the ability of the individual to recognize certain abnormal signs, that may lead one to suspect cancer, has been and increasingly should be the prime objective in our lay education program. There are, of course, other aspects of cancer control education that should be included in a well-rounded program, and it is my hope that an even more co-ordinated effort can be accomplished to this end by the combined efforts, perhaps working through a liaison committee of the Michigan State Medical Society, the Michigan Department of Health, and the two divisions in Michigan of the American Cancer Society.

Secondly, it follows that if we urge people to recognize signs of cancer and they are inclined to act on their observation, we should not fail in our responsibility to listen to them and see that they are satisfied that everything is being done to prove the presence or absence of cancer to the best of our ability. Certainly, much has been accomplished by a simple but effective plan as in Michigan's own Hillsdale and Van Buren Counties to implement cancer detection, but it can be even more simple if *every* physician would conscientiously make his office a cancer detection center. It may or may not be that this is the answer to the problem, but it behooves every one of us to be willing to respect our patients' observations and even their anxieties over their own condition. No M.D. may discuss lightly what to the patient is important and indeed may be diagnostic perhaps more times than we are willing to believe.

R. J. Hubbell

President, Michigan
State Medical Society

President's

Message

A Physician's Thanksgiving

ALMIGHTY GOD, I am thankful for the task Thou hast given me. I am thankful for the science of my profession that overcomes superstition and clarifies the true nature of disease. I am thankful for the means of practice so generously placed at my disposal and for the art of my calling. I am thankful for the strength of my physical being that permits me to minister to the weak and needy and for the courage of my soul that enables me to endure the spectacle of human suffering. I am thankful for the faith and friendship of my colleagues who so willingly come to my assistance and generously overlook my shortcomings. I am thankful for my failures and the priceless lessons they have taught, for they drive from me conceit and thoughts of easy victory and urge me to greater and more perfect attainments. I am thankful for the pitfalls and disappointments that surround and beset me, that teach me caution and protect me from hasty judgment and actions. I am thankful for ingratitude that teaches human understanding and for the gratitude that is my most lasting reward. God of human destiny, I am thankful for Thy manifold blessings and for the privilege that is mine.

E. C. Baumgarten, M.D.
November 26, 1929

Editorial

AMA STILL FIGHTS SOCIALISM

DURING THE session of the House of Delegates of the Michigan State Medical Society, in Detroit, September 22, 1952, the delegates and members were greeted on Tuesday morning with the following announcement in the *Detroit Free Press:*

SATISFIED AMERICAN MEDICAL ASSOCIATION ENDS FIGHT ON HEALTH PLAN

Chicago—The American Medical Association Monday ended its stormy, four-year fight against national compulsory health insurance, contending that it has been "eminently successful."

Leaders of the American Medical Association campaign resigned from their posts to form a committee in support of Dwight D. Eisenhower, the Republican candidate for president.

Dr. Louis H. Bauer, American Medical Association president, said the battle against what the medical group called "socialized medicine" was terminated because it had served its purpose.

A *plan* for compulsory national health insurance was advanced by President Truman, but never made any headway in Congress.

Bauer also announced the resignation of Dr. Elmer L. Henderson, chairman of the American Medical Association Co-ordinating Committee, and Clem Whitaker and Leone Baxter, directors of the American Medical Association national education campaign.

They resigned, Henderson said, to form a "National Professional Committee for Eisenhower and Nixon," which will seek to enlist the support of doctors, dentists, pharmacists, lawyers and other professional groups behind the Republican ticket.

He said the American Medical Association "is a nonpartisan, professional organization, and cannot participate in the presidential election campaign."

"Whitaker and Miss Baxter, a public relations team, along with Henderson, directed the American Medical Association's vigorous and often bitter battle against health insurance from the inception of the drive in January, 1949.

To finance the fight the American Medical Association assessed each member $25 to raise a war chest of $3,000,000.

The medical men in attendance in Detroit on September 22-23 could scarcely believe their senses, and the House adopted a resolution pledging the Michigan State Medical Society to a continued opposition to the advancement of Socialized Medicine, and asking the parent organization for an explanation.

The next day Louis H. Bauer, M.D., American Medical Association president, attended our Annual Session and gave an assurance. The fight against the socializing program, the fight to maintain the independence of the medical profession has been carried on actively for four years, but now has evolved into a political partisan fight, one party against the other. The American Medical Association is a scientific organization, not allowed morally or ethically to support a political party or candidate. It was therefore determined to withdraw from this active campaign, and allow the workers to make a new association and devote their efforts to a whole-hearted and unhindered program. We quote Dr. Bauer's release:

"Dr. Elmer L. Henderson of Louisville, Kentucky, Chairman of the Association's Co-ordinating Committee, which has supervised the campaign against socialized medicine, has resigned his committee chairmanship so that he may be free to participate in the presidential election campaign.

"Clem Whitaker and Leone Baxter, Directors of the American Medical Association National Education Campaign, have asked to be released from their public relations assignment for the same reason.

"These resignations mark the official termination of the American Medical Association National Education Campaign, which for the past four years has been eminently successful in arousing the American people to the dangers of socialized medicine, and which has played a vital part in accelerating the growth and development of Voluntary Health Insurance. The American Medical Association, on this occasion, wishes to thank the American people for their heartening demonstration of confidence and support.

"The American Medical Association, as a nonpartisan, professional organization, is barred, both ethically and legally, from participating in election campaigns, which explains the action of Dr. Henderson and Mr. Whitaker and Miss Baxter in asking for their release from American Medical Association duties. The association will take no part in the presidential election, except to join with other nonpartisan groups in urging all eligible voters to cast their ballots on election day, regardless of their affiliations or preferences. Individual doctors, of course, are entirely free to engage in election activities and, in fact, have a very real responsibility to make their influence felt for good government."

Dr. Bauer assured The Council of the Michigan State Medical Society that the American Medical Association is just as opposed as ever to the socializing of medicine, and if the need arises will be unreservedly back in the fight.

TRUMAN'S BIT—AMA REPLY

AT HIS press conference President Truman said that from press reports he had seen "he had the impression that the American Medical Association was giving up, and acceding to his demands for a national compulsory health insurance program." There was confusion in the way some of the stories were written; headlines, especially, gave some readers that impression. But, this was not true.

The President added to the misunderstanding when he said he thought his Philadelphia speech on medical care for the American people—the speech he delivered before the American Hospital Association—caused the American Medical Association to disband its organization setup to fight his national health program.

He asserted the American Medical Association officials admit now by their action that they have been wrong.

The President of the American Medical Association, Louis H. Bauer, M.D., in Chicago, quickly issued a statement to the press, saying that Mr. Truman had some mistaken ideas about the American Medical Association's giving up.

"The American Medical Association will never cease its fight against national compulsory health insurance," Dr. Bauer's statement said, adding: "Mr. Truman's Philadelphia speech had no bearing whatsoever on the decision to disband a special committee set up to conduct an intensive short term, educational program against socialized medicine. This decision was reached by the American Medical Association House of Delegates last June, and was widely publicized at the time.

"The National Education Campaign was merely one intensive phase in the medical profession's long-range effort to keep medical care on a voluntary basis. This effort will continue as long as attempts are made to shackle the people's health in bureaucratic red tape.

"Mr. Truman is naive indeed if he believes that any speech he delivers could change the medical profession's basic beliefs concerning high quality medical care."

THE DOCTOR AND HIS CORONARIES

THERE IS a general belief that the doctor is somewhat more susceptible to coronary disease than the rest of the population. This was recently given additional support by a study in England which found a higher incidence of this disease among general practitioners than in either specialists and consultants or civilians. All of which quite naturally sets the doctor to wondering why he has achieved this unwelcome distinction and what he can do about it.

The answer is not readily available. At least not until more is known about heredity, body build and the habits we acquire defensively such as smoking, overeating and underexercising. The nature of the occupation itself, with the wide swings in its demands and the variation in imposed stress, offers a tempting explanation but does not disclose why the arteries to the brain and kidney should not break down as readily as those to the heart muscle.

Studies on the stress reaction, on the steroid chemistry in the body and on lipid metabolism hold some promise, but the prevailing attempts at influencing these in the human are still unimpressive. Until some more startling revelation comes along we should follow the same advice we give our patients: to eat, drink, smoke and play moderately; to rest adequately; and to have ourselves examined more frequently. This may at least put us on a par with the average citizen.

WILLIAM S. REVENO, M.D.

Elections

PRESIDENT FOR A DAY

THE MICHIGAN State Medical Society is well known throughout the land as an organization which does new things, makes new plans, takes a lead in medical progress, both scientifically and economically. There are so many "Michigan Firsts" that we hesitate to even enumerate them. However, there is one project which shows a very unusual and striking aptitude for recognizing and doing honor to its deserving members. Three years ago the House of Delegates designated the Editor as President for a Day. We value this honor as the highest in the gift of the society. Again the House of Delegates of the Michigan State Medical Society has conferred upon one of its honored members the most exclusive, and highest honor it can confer. It is given to one of our members most deserving by any standard. It is a recognition of eleven years of the most devoted and arduous work on behalf of the medical profession, the people of our State, and the advancement of our unrelenting fight against the socialization of our profession, all with absolutely no recompense except the knowledge and satisfaction of a tremendous task well done.

Robert L. Novy, M.D., of Detroit, was chosen by unanimous vote as President for a Day. He wore the badge of office from the meeting of the House on the evening of September 22, 1952, to

PRESIDENT-FOR-A-DAY
R. L. NOVY, M.D.

the meeting of the Biddle Lecture, September 23.

Dr. Novy was born April 1, 1892, in Ann Arbor. He married Elsie Lois Backus in 1916, has six children and eight grandchildren.

Dr. Novy's education was: He was graduated from the Ann Arbor High School in 1909, received an A.B. degree from the University of Michigan in 1913, and an M.S. in Organic Chemistry, 1914. He was instructor in charge of premedic chemistry and assisting in physiological chemistry, at the University of Iowa, 1914-15. He received his M.D. from the University of Michigan in 1919, and interned at Peter Bent Brigham Hospital and Boston City Contagious Hospital. He was a Fellow and Instructor in cardiology at Washington University, St. Louis, Mo., and in charge of cardiology at Barnes Hospital from 1921-1922. Dr. Novy has been in practice in Detroit from 1922 to this date, specializing in internal medicine and cardiology. He is a diplomate in cardiology.

Dr. Novy's professional and extracurricular activities show an unusual interest in the welfare of the profession, and good service to the people as exemplified by his decided influence on the Blue Shield movement of the nation.

We list Dr. Novy's activities:

Elected to Michigan Medical Service Board of Directors in 1941; President of Michigan Medical Service, 1942 to date.

Member and President of Detroit Board of Health, 1940 to date.

Instructor and Professor of Clinical Medicine, Wayne University Medical School, 1922 to date.

One time extramural lecturer, University of Michigan Medical School.

Wayne County Delegate to Michigan State Medical Society.

Michigan Delegate to the American Medical Association.

Former Trustee, Wayne County Medical Society.

Commissioner-at-large and Vice President, National Blue Shield Care Plans.

Member of Board of Trustees of Michigan Hospital Service.

Chairman of Michigan State Medical Society Committee on Fee Schedules.

Senior Physician, Harper Hospital.

Consultant and member of staff of number of hospitals.

Recreation: hunting, camping, fishing and photography.

PRESIDENT

READER J. HUBBELL, M.D., of Kalamazoo, was advanced from president-elect to president of the Michigan State Medical Society. Dr. Hubbell is a graduate of Northwestern University Medical School, 1923. He is a Fellow of the American College of Surgeons, and a diplomate of the American Board of Urology. He has held many staff and professional positions in his home hospitals and medical societies. He served on the Council of the Michigan State Medical Society for many years, and was chairman from 1950 to 1951.

PRESIDENT-ELECT

LEROY W. HULL, M.D., of Detroit, was elected president-elect. Dr. Hull was born June 3, 1888, in Lawrenceville, New Jersey. He was educated at the University of Michigan with the degree of A.B. in 1909, and M.D. in 1911. He interned at the Calumet and Heckla Mining Company Hospital, 1911-1912 and was physician at the Winona, Michigan, Mining Company, 1912-1915. He engaged in private practice of medicine and urology, in Detroit, in 1915. He was attending urologist at Receiving Hospital, Detroit, 1925-1942, and at Grace Hospital. He was made

chief of the Urology Department at Grace Hospital in 1948. Dr. Hull was Clinical Instructor, Wayne University Medical School, 1935-1942. He was instructor in the Department of Postgraduate Medicine at the University of Michigan in 1936. He is a member of the Wayne County Medical Society; president, 1944-1945 and trustee, 1945-1950. Dr. Hull was a member of the Council, Michigan State Medical Society, 1949-1952, and vice chairman, 1952. He is a member of the American Medical Association, the American Urological Association, the Detroit Urological Society (president 1929 and 1940), member of the North Central Branch, the Detroit Academy of Medicine, Delta Upsilon and Nu Sigma Nu.

Dr. Hull's election as president-elect made his place on the Council vacant.

THE COUNCIL

THE COUNCILORS of the seventh, eighth, ninth and tenth districts whose terms expired this year were all re-elected: H. B. Zimmer, M.D., Lapeer; L. C. Harvey, M.D., Saginaw; G. B. Saltenstall, M.D., Charlevoix, and Fred H. Drummond, M.D., Kawkawlin.

ARCH WALLS, M.D.

One new Councilor elected by the House of Delegates at the annual session in September, 1952, was Dr. Arch Walls of Detroit. Dr. Walls will fill the unexpired term of Dr. Hull, Councilor from the first district, who was elected president-elect.

Dr. Walls was born in 1895 in Pontiac and received his medical degree from the University of Michigan in 1923. He interned at Harper Hospital, and is on the staff of Florence Crittendon Hospital. He has been an active member of the Wayne County Medical Society since 1923; president in 1951-1952; secretary, 1944-1945, and trustee, 1949-1951. He was delegate to the Michigan State Medical Society; chairman of the Post-War Planning Committee; chairman of the Entertainment Committee; member of the Medical Advisory Committee of Michigan Medical Service; chairman of the Movie Subcommittee of the Public Relations Committee of the Michigan State Medical Society, and chairman of the Public Relations Committee of the MSMS.

Dr. Walls has been very active in promoting the interests of the general practitioners. He was a leader in organizing the first general practice section in various hospitals; one of the members of the American Academy of General Practice, past president of the Wayne County division of the American Academy of General Practice and past chairman of the Board of the Academy.

He and his wife, Lucille, have two children, Robert and Jean. He is a member of the Plum Hollow Country Club and the Detroit Athletic Club.

The House of Delegates re-elected Robert H. Baker, M.D., Pontiac, as speaker, and J. E. Livesay, M.D., Flint, vice speaker. L. Fernald Foster, M.D., Bay City, holds over as secretary and Wm. A. Hyland, M.D., Grand Rapids, as treasurer.

During the session of the Michigan State Medical Society, elections to the Board of Directors were held. The following were elected to succeed themselves: Earl I. Carr, M.D., Lansing; J. S. DeTar, M.D., Milan; Carelton Fox, D.D.S., Detroit; Wilfrid Haughey, M.D., Battle Creek; E. F. Sladek, M.D., Traverse City; W. I. Stoddard, Grand Rapids; Ronald Yaw, Grand Rapids, and William Bromme, M.D., Detroit. Mr. Glen W. Fausey, superintendent of the Edward Sparrow Hospital, Lansing, was elected as a new member of the board, representing the Michigan Hospital Association.

The Board of Directors at its organization meeting, October 8, 1952, in Detroit re-elected its officers: Robert L. Novy, M.D., Detroit, president; Wilfrid Haughey, M.D., Battle Creek, vice president; Robert H. Baker, M.D., Pontiac, secretary, and Waldo I. Stoddard, vice president, Michigan National Bank, Grand Rapids, treasurer.

MSMS

WHY IS A YAWN "CATCHING?"

Yawning may be considered to be a form of inspiration tic, associated with dyspnea. P. Janet describes yawning as related to sighing, sobbing, and hiccoughing, and refers to it as an example of "imitative contagion" (The Major Symptom of Hysteria, New York, The Macmillan Company, 1907, p. 259). It is a complex nervous respiratory reflex associated with mild boredom, irritating mental effort, or mild emotional anxiety. It is classified by R. Burton-Opitz (A Textbook of Physiology: For Students and Practitioners of Medicine, Philadelphia, W. B. Saunders Company, 1920, pp. 592-593) among the association or perception reflexes. These "skirt the realm of volition without being actually influenced by it and may be invoked in us in consequence of a visual impression of some one else already engaged in the act." Yawning is catching as a conditioned visual reflex when persons in a group are subjected to the same general boring or frustrating environment.—From "Queries & Minor Notes," *J.A.M.A.*, 148:16 (August 16) 1952.

FROM THE MINDS OF MEN - - -

- - - - THE BIRTH OF AN IDEA

1943 -- Michigan Health Council -- 1952

Reproduced on the cover of this issue of THE JOURNAL is a graphic record of the origin of the Michigan Health Council.

Taken in Detroit on November 3, 1943, this picture* shows eight of the ten men who accepted the challenge to transform an idea into a going concern—The Michigan Health Council.

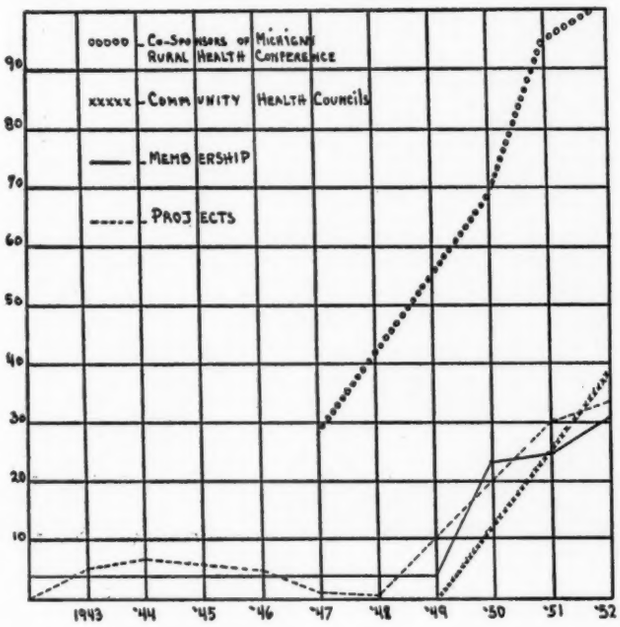
With the conviction that a state-wide health council organization could be an effective co-ordinating vehicle in health, this group came together in regular monthly meetings to explore the possibilities and crystallize the idea.

Early in their deliberations the committee framed the purposes of the Michigan Health Council program and unanimously adopted the following basic objectives:

TO PROMOTE THE HEALTH OF THE PEOPLE BY:

1. Co-ordinating the efforts of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, Michigan Hospital Service and other groups interested in the health of the people.
2. Conducting a general educational program regarding the advantages to the health of the people to be gained through the private practice of medicine and dentistry, and the operation of voluntary non-profit hospitals.
3. Taking all necessary and practical steps to arrange for the availability of medical, dental, hospital and related services.

Growth Chart



Proof of the soundness of their thinking lies in the fact that while the program has been expanded in many directions since 1943, the original basic objectives still prevail.

During recent years more emphasis has been focused on Items 2 and 3 mentioned above while Item 1—co-ordination of the efforts of Michigan State Medical Society, Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service—has been accomplished effectively by a joint effort of all, with Michigan Health Council co-operating in every manner possible.

Progress in the development of the idea, defined in those early meetings, is shown on the accompanying growth chart. Four basic factors of growth are recorded on this chart: (1) growth of voting membership; (2) expansion of associate membership; (3) increase in the number of projects, and (4) growth in the number of organizations co-sponsoring the annual Michigan Rural Health Conference.

***Cover Photo**—left to right—Graham L. Davis; A. S. Brunk, M.D. (deceased); R. L. Novy, M.D.; C. E. Umphrey, M.D.; Jay C. Ketchum; L. S. Woodworth, M.D.; John R. Mannix; L. V. Ragsdale, M.D.; also on the original committee, but not shown in this photograph were: W. E. Barstow, M.D., and William J. Griffin.

Continuing Projects Expanded

One factor responsible for the steady growth of the total program is the continuing nature of the projects making up the total MHC program. With but one exception, every project adopted since the Expanded Activities Program was launched in 1949, is still in being, and in the process of expansion.

That one project was the work done in collaboration with Brookings Institution in their study of Health Resources in the United States, for which MHC was given credit in the preface of the volume just released. There is a possibility that even this project may be reopened and continued if present negotiations for publication of the Michigan findings materialize.

New Projects Launched

The growth chart accompanying this article shows the gradual increase in the total number of projects adopted and emphasizes the marked expansion during the past three years.

Newest projects added to the MHC "Parade of Projects" (JMSMS—November, 1951) are: (1) periodic health appraisal; (2) Medical Associates procurement; (3) weekly television series, The Court of Health —all of which are being guided by special subcommittees on which doctors of medicine serve.

Registration Desk
Michigan Rural Health Council

M.D. Participation Increased

One of the important factors in the growth of the MHC program lies in the ever-increasing participation of Michigan doctors of Medicine (JMSMS—November, 1950). This participation has been present ever since the inception of the Council, as evidenced in the cover photograph, with the circle ever widening into all areas of Michigan and all branches of medicine.

To cite specific instances of this increasing M.D. participation, the following areas of co-operation might be considered:

1. *MHC Weekly Television Program, "The Court of Health."*—While this series has been produced by MHC only since June, 1952, more than twenty Michigan doctors of medicine have appeared on the program. Others are already scheduled for appearance in the near future. Appearing in another part of this article is a list of names of the doctors of medicine who have given of their time and knowledge to make this television series a success.

2. *Fifth Annual Rural Health Conference.*—Sponsored by the Michigan Foundation for Medical and Health Education and co-sponsored by ninety-four Michigan health groups, doctors of medicine from various areas of the state attended and participated. Eight doctors of medicine made scheduled appearances on the two-day program contributing effectively to the success of the conference.

3. *Counsel in Membership Expansion.*—Michigan doctors of medicine have been helpful in counseling member organizations on the advantages of affiliating with Michigan Health Council. Serving on boards of ancillary medical groups they have been in a position to counsel their groups on the effective utilization of the various MHC services available to them as member organizations. On numerous occasions they have given freely of knowledge and time in guiding various MHC projects.

4. *Community Health Council Activities.*—During the past year there has been a noticeable increase in M.D. participation in Community Health Council activities. In some instances doctors have played an important part in organizing of Community Health Councils and on many other occasions have given valuable advice to these community groups in planning and implementing community health programs.

Continued Growth Anticipated

Thus, starting with something as intangible as an idea—a very tangible organization has evolved.

Under the capable leadership of the late A. S. Brunk, M.D., first president, and the continued stimulation and guidance of President J. S. DeTar, M.D., the Michigan Health Council looks forward to an ever-broadening horizon of service.

With the continued co-operation and participation of Michigan doctors of medicine, further growth is assured.

The Court of Health

MHC Weekly Television Series

Working in the friendly atmosphere afforded all medical and health groups, Michigan doctors of medicine have played an important part in the new MHC weekly television series, "The Court of Health."

Carried over WJBK-TV, Detroit (Channel 2) Sundays, 10:30 to 11:00 A.M., the series features programs from three basic sources of material: (1) MHC member organizations, (2) Community Health Councils, (3) Seasonal health subjects.

With this wide variety of material, resources and personnel on which to draw, MHC has been able to cut across a broad field of medical and health subjects. In so doing, MHC has called freely on the knowledge and experience of Michigan doctors of medicine who have responded in a genial manner.

While the show is now beamed to the greater Detroit area, consideration is now being given to the possibility of utilizing the facilities of kinescope to broaden the range to the entire state of Michigan.

Michigan Heart Association
"New Hope for Hearts"

(Left to right)—Frederic Johnson, M.D., Detroit, Wayne University College of Medicine; "Judge" Morris; Mrs. Hugh Wilson, Ann Arbor, President, Michigan Heart Association.

"Farm Safety Week"

(Left to right)—William Buchinger, Farm Safety Engineer, Detroit Edison Company; "Judge" Morris, professional moderator; Robert Richards, Lansing, Past President, Michigan Safety Council.

Michigan M.D.'s who have appeared as guests and resource persons on MHC television series, "The Court of Health"—10:30 A.M., Sundays, WJBK-TV Detroit—Channel 2.

1. Otto O. Beck, Birmingham
2. J. K. Altland, Lansing
3. Arthur E. Schiller, Detroit
4. Frederic Johnson, Detroit
5. J. N. Mandiberg, Detroit
6. Thomas Francis, Jr., Ann Arbor
7. E. A. Irvin, Detroit
8. Clifford H. Keene, Ypsilanti
9. W. A. Dawson, Inkster
10. W. H. Kern, Garden City
11. Arch Walls, Detroit
12. L. Fernald Foster, Bay City
13. G. W. Slagle, Battle Creek
14. W. S. Jones, Menominee
15. R. W. Shook, Kalamazoo
16. Oscar Stryker, Mt. Clemens
17. Geo. C. Thosteson, Detroit
18. W. L. Anderson, Detroit
19. Wm. L. Simpson, Detroit
20. A. D. Reudemann, Detroit
21. Carleton Dean, Lansing

87th Annual Session Highlights

DETROIT SCENE OF LARGEST SCIENTIFIC-SOCIAL MSMS MEETING

A record registration marked the 87th Annual Session in Detroit—despite conflicts with two national medical meetings!

MICHIGAN'S FOREMOST FAMILY PHYSICIAN

President R. J. Hubbell, M.D., of Kalamazoo, congratulating Michigan's Foremost Family Physician, S. L. Loupee, M.D., of Dowagiac, while Otto O. Beck, M.D., Birmingham, looks on. Dr. Loupee was selected as the 1952 foremost practitioner by the MSMS House of Delegates.

For years (six to be exact) the last full week in September has been reserved by the Michigan State Medical Society for its Annual Sessions. This year two national medical groups (the American College of Surgeons and the American Roentgen Ray Society) arranged their conventions the same week as the MSMS Session in Detroit. What that conflict did to their attendance is not known—but the clash had no effect whatever on the grand total that gathered at the Sheraton-Cadillac Hotel for one inspired week in September, 1952! The total registration, including the ladies, was 3,605.

ATTENDANCE RECORD SMASHED AT 1952 MEETING

Total registration at the 87th Annual Session of the Michigan State Medical Society in Detroit, September 24 to 26, was 3,605, the largest total for MSMS!

The breakdown included:

Doctors of Medicine	2163
Guests	419
Exhibitors	507
Woman's Auxiliary Members	273
Medical Assistants Members	243
GRAND TOTAL	3605

AMA-MSMS Cooperation

Three presidents using a triple handshake symbolize the unity between the AMA and MSMS. Pictured *(left to right)* are Otto O. Beck, M.D., Birmingham, 1951-52 MSMS President; Louis H. Bauer, M.D., Hempstead, N. Y., AMA President; and R. J. Hubbell, M.D., Kalamazoo, 1952-53 MSMS President.

New Top Officers

R. J. Hubbell, M.D., of Kalamazoo *(right)*, 1952-53 President MSMS, congratulates President-Elect L. W. Hull, M.D. of Detroit. Dr. Hull was elected by members of the MSMS House of Delegates to assume the presidency on September 23, 1953.

New Honorary Members

(Right) Grins reward President Otto O. Beck, M.D., of Birmingham *(center)*, as he rehearses his presentation talk prior to Officers' Night ceremonies when he awarded MSMS honorary membership certificates to State Treasurer D. Hale Brake, Lansing *(left)*, and Paul de Kruif, Holland *(right)*.

Two thousand one hundred sixty-three (2,163) doctors of medicine heard lectures by twenty-four eminent teachers and clinicians, listened to AMA President Louis H. Bauer, M.D., of New York State, and heard an outstandingly vigorous Biddle Lecture presented by Paul de Kruif, Ph.D., of Holland, Michigan.

These Michigan doctors of medicine selected Sherman L. Loupee, M.D., of Dowagiac as Michigan's Foremost Family Physician for 1952, honored an additional eleven physicians with fifty years of practice, honored two Presidents during the Session—Otto O. Beck, M.D., of Birmingham, and also President-for-a-Day R. L. Novy, M.D., Detroit, who received this great honor from the House of Delegates on September 22, 1952. The doctors viewed ninety-nine interesting and instructive exhibits, attended eighteen additional meetings of special societies, alumni and auxiliary groups, named a President-Elect from Detroit, and incidentally had a wonderful time with old friends and new ones.

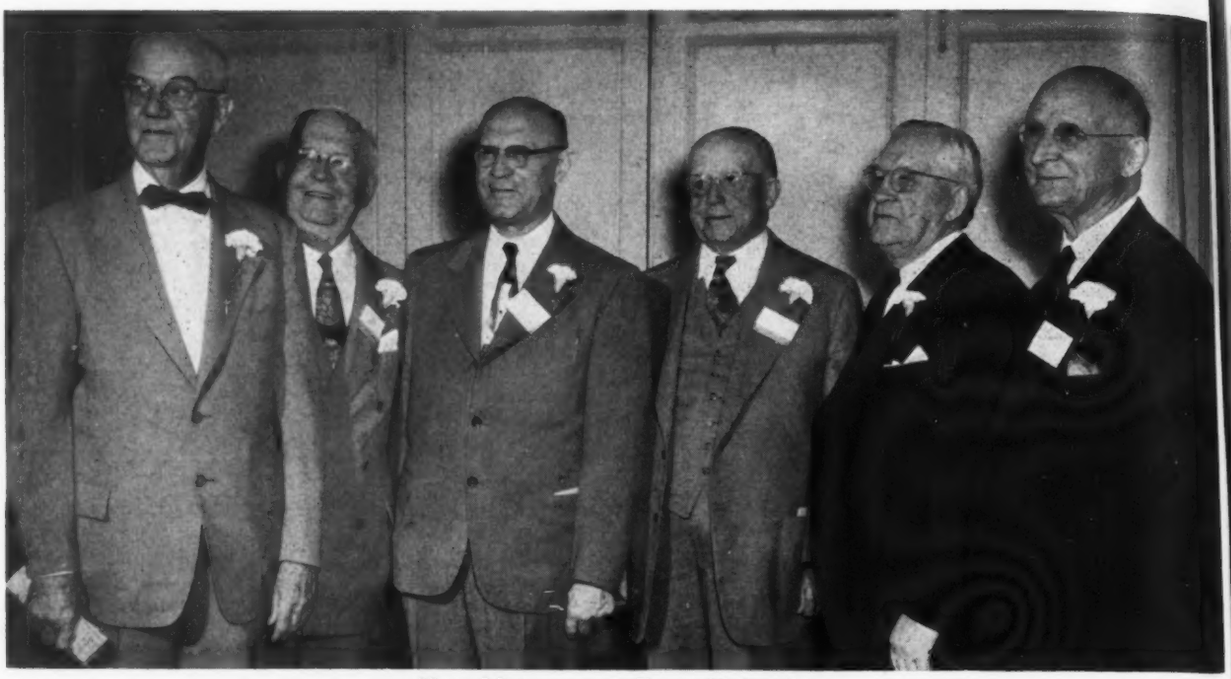
Every meeting room in the Sheraton-Cadillac Hotel was jampacked with activity. Suite 500 was one of the spots that buzzed during the two days of the MSMS House of Delegates meeting and during the three days of the scientific presentations. Everyday, top-notch reporters from Detroit papers and the wire services of Associated Press and United Press were on the job pouring out accurate, complete and widespread coverage; in one week's time, thousands of words were written and flashed all over Michigan as well as to many parts of the United States, about the great MSMS Annual Session of 1952.

"Cap" Potter's Work Recognized

William Bromme, M.D., Detroit *(right)*, Chairman of the MSMS Council, congratulates L. A. ("Cap") Potter, of the Michigan Department of Health, after Mr. Potter was awarded a scroll signifying honorary membership in MSMS.

PRESIDENT BAUER AFFIRMS AMA IS STILL FIGHTING SOCIALISM

One of the highlights of Officers Night, held in the Grand Ballroom of the Sheraton-Cadillac Ho-



NEW MEMBERS OF FIFTY YEAR CLUB

Representing 300 years of service to the medical profession, six members of the MSMS "Fifty Year Club" line up for their photograph before receiving the "Fifty Year Club" pins at Officers' Night ceremonies of the 1952 Annual Session. *(Left to right)* M. E. Danforth, of Detroit; W. J. Jend, M.D., of Detroit; J. E. Cooper, M.D., of Battle Creek; A. L. Robinson, M.D., of Burr Oak; M. J. Uloth, M.D., Ortonville; and H. A. Herzer, M.D., Albion. Other 1952 members of the "Fifty Year Club" not pictured are: W. A. Grant, M.D., Milford; G. P. Raynale, M.D., Birmingham; W. E. Keane, M.D., Detroit; Edgar T. Morris, M.D., Nashville, and B. L. Franklin, M.D., Remus.

tel on Wednesday evening, September 24, was the address of Louis H. Bauer, M.D., of Hempstead, L. I., President of the AMA and Secretary of World Medical Association. Dr. Bauer decried the published reports that the AMA was finished with its fight against socialism. He stated defi-

PRESS CONFERENCE AND COFFEE

Detroit science writers interviewing guest essayists in the busy Press Room at 1952 MSMS Annual Session.

MRS. MACKERSIE ACCEPTS WOMAN'S AUXILIARY GAVEL

Mrs. Robert S. Breakey, Lansing, retiring President of the Woman's Auxiliary to MSMS, presents the symbol of office to incoming President, Mrs. William G. Mackersie, Detroit. The Auxiliary held its 26th Annual Convention concurrently with the 1952 Annual Session in Detroit. *(Left to right)* Mrs. Russell T. Costello, Detroit, President, Wayne County Woman's Auxiliary; President Mackersie; Mrs. Harold H. Gay, Midland, Financial Secretary, MSMS Woman's Auxiliary; Mrs. Breakey; Mrs. A. F. Milford, Ypsilanti *(in background,)* First Vice President; Mrs. Walter S. Stinson, Bay City, President-Elect.

nitely and vigorously that the AMA never would let down in its battle against the forces of bureaucracy. Dr. Bauer's powerful address will be published in a later issue of JMSMS.

The Biddle Lecture of Paul de Kruif was a masterly delineation by a powerful moulder of

THE TECHNICAL EXHIBIT

A corner of the ever-busy Technical Exhibit during the 1952 MSMS Annual Session.

SCHEDULE OF TALKS DURING ANNUAL SESSION

Telecasts

L. Fernald Foster, M.D., Bay City Arch Walls, M.D., Detroit	WJBK-TV	Sept. 14
W. S. Jones, M.D., Menominee G. W. Slagle, M.D., Battle Creek R. W. Shook, M.D., Kalamazoo	WJBK-TV	Sept. 21
House of Delegates Newscast	WJBK-TV	Sept. 22
John R. Rodger, M.D., Bellaire	WXYZ-TV	Sept. 22
R. J. Hubbell, M.D., Kalamazoo S. L. Loupee, M.D., Dowagiac	WJBK-TV	Sept. 23
S. L. Loupee, M.D., Dowagiac	WWJ-TV	Sept. 23
L. Fernald Foster, M.D., Bay City R. A. Johnson, M.D., Detroit R. H. Baker, M.D., Pontiac	WJBK-TV	Sept. 24
E. F. Sladek, M.D., Traverse City S. L. Loupee, M.D., Dowagiac	WXYZ-TV	Sept. 24
Mrs. Wm. Mackersie, Detroit Mrs. A. F. Milford, Ypsilanti	WJBK-TV	Sept. 28

Radio Broadcasts

William Bromme, M.D., Detroit	WJBK	Sept. 22
R. J. Hubbell, M.D., Kalamazoo	WJR	Sept. 23
R. J. Hubbell, M.D., Kalamazoo	WKZO	Sept. 23
Stuart V. Smith, Wyeth, Inc., Phila. Harvey Merker, Parke Davis & Co., Detroit Mrs. George L. Stokes, Flint	WWJ	Sept. 23
R. J. Hubbell, M.D., Kalamazoo L. W. Hull, M.D., Detroit R. L. Novy, M.D., Detroit	WWJ	Sept. 24
J. E. Livesay, M.D., Flint	CKLW	Sept. 24
Otto O. Beck, M.D., Birmingham	WWJ	Sept. 25

Service Club Talks

H. B. Zemmer, M.D., Lapeer	Central Kiwanis	Sept. 22
Hugh W. Brenneman, Lansing	Kiwanis	Sept. 23
Otto O. Beck, M.D., Birmingham	Lions	Sept. 30

public opinion. Dr. de Kruif, roving Editor for *Reader's Digest*, cleverly covered in thirty minutes a wide area of both scientific medicine and its social and economic problems. Dr. de Kruif's masterpiece appeared in the October number.

THE BIG EXHIBIT WAS LIKED

The ninety-nine exhibits were terrific and each seemed to provide inspiration and impact. In some respects, this year's exhibits were as interesting and desirable to doctors of medicine as the papers presented in the meeting room; the exhibit section brought tangible values to the many hundreds who inspected it. Michigan M.D.'s found there's always something *new* in the MSMS exhibit.

Ubiquitous Hosts did a masterful job of making the guest speakers feel "at home" in Michigan. The following doctors of medicine placed themselves at the disposal of the visiting guest essayists who were on the program of the Annual Session—they demonstrated the meaning of Michigan hospitality to the eminent speakers from other parts of the United States: Otto O. Beck, M.D., Birmingham; G. B. Saltonstall, M.D., Charlevoix; W. W. Babcock, M.D., A. E. Catherwood, M.D., W. C. C. Cole, M.D., Edward Conner, M.D., P. J. Connolly, M.D., W. B. Cooksey, M.D., J. D. Fryfogle, M.D., E. S. Gurdjian, M.D., G. E. Hause, M.D., Benjamin Jeffries, M.D., S. J. Joyce, M.D., C. R. Lam, M.D., J. E. Lofstrom, M.D., G. T. McKean, M.D., R. M. McKean, M.D., W. G. Mackersie, M.D., J. G. Molner, M.D., H. V. Morley, M.D., R. L. Novy, M.D., E. A. Osius, M.D., J. P. Ottaway, M.D., P. S. Peven, M.D., R. P. Reynolds, M.D., F. S. Ryerson, M.D., A. E. Schiller, M.D., E. J. Shumaker, M.D., E. D. Spalding, M.D., C. N. Swanson, M.D., C. E. Umphrey, M.D., Wadsworth Warren, M.D., J. E. Webster, M.D., all of Detroit; and J. D. Miller, Grand Rapids.

THE COUNCIL MEETS THREE TIMES DURING ANNUAL SESSION

The twenty-five members of The Council held three meetings during the days of the MSMS Annual Session in Detroit. Elsewhere in this issue is a summary of the actions taken by The Council at the September Session. The Council placed upon its minutes a sincere vote of hearty thanks to all who helped in any way to make successful the record-breaking Annual Session of the Michigan State Medical Society in Detroit, September, 1952.

Report of Special Committee

The Joint Committee of Michigan State Medical Society and Michigan Hospital Association to Survey Medical and Hospital Facilities at the State Prison of Southern Michigan has submitted the following report to the Michigan Correction Commission.

Because of the excellent improvement made in the health program at Jackson Prison in the past five years, it is with considerable pleasure that the present report is submitted. It is of note that three of the four members of this Committee were members of the same committee which inspected the prison hospital facilities in 1947. A very detailed report was submitted at that time and many criticisms and recommendations were made. The present report omits many of the details describing the physical setup contained in that report and is more in the nature of a follow-up, plus a general inspection. The inspection was made May 7, 1952.

I. Population—May, 1952

The hospital serves an inmate population of approximately 6,500—an increase of 700 inmates over the 1947 population of 5,800. This is in excess by almost 1,000 inmates of the number for whom the prison was originally built. This overcrowding shows itself in every facet of prison life and is especially noticeable in the hospital facilities in that such facilities which might reasonably be used for the segregation of sex perverts, psychiatric inmates and tuberculosis patients are utilized for general prisoner care to the detriment of any definite and objective care and rehabilitation of the above-mentioned groups.

II. Inspection of Prison Hospital Physical Plant

A detailed description of the hospital is contained in the previous report and is omitted here. A comparison of 1947 and 1952 is astounding and a very great improvement is noted:

(1) it is now clean and sanitary; (2) records are well kept, accurate and complete; (3) patients' diets are posted on each cell door—special diets for diabetics and other inmates needing dietary are obtainable; (4) x-ray and laboratory facilities are excellent; (5) dental setup and program is clean and adequate; (6) eye clinic well run and adequate; (7) Pharmacy—well kept and clean—records good, excellent control of narcotics, barbiturates, and other special drugs.

It is almost impossible to believe so much progress has been accomplished.

Especially worthy of mention are the blood donations of 3,375 pints of blood to the Armed Forces and 1,753 pints to ill prison hospital patients.

III. Personnel and Service

There are now four full time physicians employed at the prison. Only Dr. R. L. Finch, head prison physician, was interviewed although the qualifications of the others were reviewed. All seemed adequate and a marked improvement in organizational work and defined allocations of duty were noticed.

Some 10,000 formal consultations were noted in the different medical specialties and of worthy mention is the fact that in spite of a marked population increase, the number of hospital deaths has not changed. Particular praise should be given to the University of Michigan Hospital which regularly sends physician teams or individuals to perform surgery of all kinds and consult in all of the medical specialties including allergy, dermatology, et cetera.

There is no question but what the acute hospital care of prison inmates is greatly improved over that of 1947. This good work is sincerely applauded by the Committee and it is their earnest hope that it will be continued. There is, however, still much room for improvement in several important areas and a special section is devoted to a discussion of them with criticism and recommendations. The six are as follows:

1. *Overcrowding.*—This is basic and is a matter of record of every lay and medical investigating committee of the last five years. Its influence on the whole penal system cannot be overstressed and it has stifled reform and progress of any sort. Segregation of psychiatrical patients, sexual perverts and tuberculosis patients is fundamental to good prison care and discipline let alone good hospital care which is impossible under present conditions.

2. *Psychiatric facilities and personnel.*—Undoubtedly the psychiatric set-up is the weakest and poorest of the entire prison medical make-up. It should be remembered that every prisoner is a potential psychiatrical problem. He would not have committed crime if he had been mentally adjusted. Prisoners should be screened on admittance to see if they are psychiatric cases. If so, they should be segregated and psychiatric rehabilitation started immediately. Instead there is no psychiatrist, no examination, no segregation and no attempt at psychiatric rehabilitation. The situation is pitiful. Prison officials acknowledge the presence of 1,500 sex perverts, over 100 bad psychotics and another 100 mild or chronic psychotics. They also state freely if there had been proper segregation there probably would have been no riot. The remedies are obvious—

(1) Immediate hiring of at least one and preferably two psychiatrists. To attract a psychiatrist he must be paid at least what psychiatrists are paid at state mental institutions and veterans facilities. (The present scale is below these levels.)

(2) Segregation of psychiatric patients.

(3) Screening program for entering inmates and rehabilitation program for those needing same.

(4) Addition of psychiatric therapy facilities.

The prison has three psychologists, and their work was only superficially scanned. No attempt was made to

evaluate their work or function. It is a fact known to all however that they are not physicians and in a situation such as exists in a prison facility they should be members of a psychiatric team under the specific direction and guidance of a psychiatrist instead of working alone.

Our state has a hospital for the Criminally Insane at Ionia. Yet only thirteen patients were transferred from Jackson to Ionia in 1951, and in turn Jackson received thirteen milder mental patients from Ionia. Ionia is itself badly overcrowded. However it is overcrowded because persons are admitted from state civilian institutions such as Kalamazoo, Pontiac and Traverse City. If Ionia is properly going to perform its function as an institution for the criminally insane, the state institutions should not be allowed to slough off their undesirable patients. This condition should be studied and made a matter of concern and definite policy by the proper governmental authorities.

3. *Tuberculosis.*—The prison hospital on inspection had sixty-nine patients with active tuberculosis on the second and first floors. There is a great need for additional space for the care and segregation of such tuberculosis patients as a means of keeping the active and convalescent cases away from other inmates and patients. Isolation for an inmate with tuberculosis at the present time amounts to practically solitary confinement and is a great hardship in maintaining his morale.

To properly care for the inmates who are infected with tuberculosis a separate building must be constructed. The State Tuberculosis Commission should seriously consider providing such a building out of the funds of five million dollars voted by the people of Michigan. Inmates having tuberculosis are not released from prison when their disease is arrested, but rather when their term expires or they are paroled. The release of an inmate with active tuberculosis is as great a hazard to the people of this state as the repetition of a crime. Every effort should be made to bring their disease under control.

4. *Nursing Care.*—Nursing care of prison hospital patients is solely in the hands of prison inmates. They are paid twelve and seven-tenths cents per day. This is below the scale paid in the prison industries and factories. It is felt their work is as important and that they should be paid a wage comparable to other prisoners.

Knowledge of proper nursing care is a hand-me-down from prison hospital attendant-inmates to their successors over the years. Bad and improper care as well as good is therefore passed on year after year. It is suggested that in the hospital budget, allocations be placed for the possible hiring of several civilian male nurses. The function of these male nurses to be that of instructing and teaching prison hospital attendants proper care of sick people.

This likewise performs the very worthwhile function of teaching inmates a profession and rehabilitating them for a job once they can be released.

5. *Geriatric Problem.*—An increase is noted in the number of inmates who are purely a geriatric (old age) custodial problem. Their numbers include those with plain old age senilities, those partially paralyzed from cerebral accidents (stroke), patients with old prostate and urological disorders, amputees and those with blood vascular changes. Legally they are as much a prisoner as anyone else because of their crime, but it is felt study should be given to this problem and some disposition made of them other than frank hospitalization.

6. *For the future planning* of new prison facilities in Michigan, the Committee is of the opinion that serious thought should be given to the classification of inmates as to moral character. Many prisoners are determined to return to society after their term expires and live useful lives. Being forced to live with the very dregs of society and be subjected to the most humiliating and degrading demands by some of their fellow inmates is unjust and unfair. We understand that our judges have the power to classify, but that they are helpless to do so because of the overcrowded prison population. We feel that this can only be accomplished with more and smaller prisons. To live with less fear and dread of fellow inmates would promote better mental and physical health.

The committee again wishes to commend Doctor Finch and his associates for the improvements that have been made and we sincerely hope that our further recommendations can be consummated.

Respectfully submitted,

For Michigan State Medical Society
PHILIP RILEY, M.D.
OTTO O. BECK, M.D.

For Michigan Hospital Association
GLEN FAUSEY
KENNETH B. BABCOCK, M.D.

THE USE OF ORAL AND TOPICAL CALCIUM PREPARATIONS IN PRURITUS

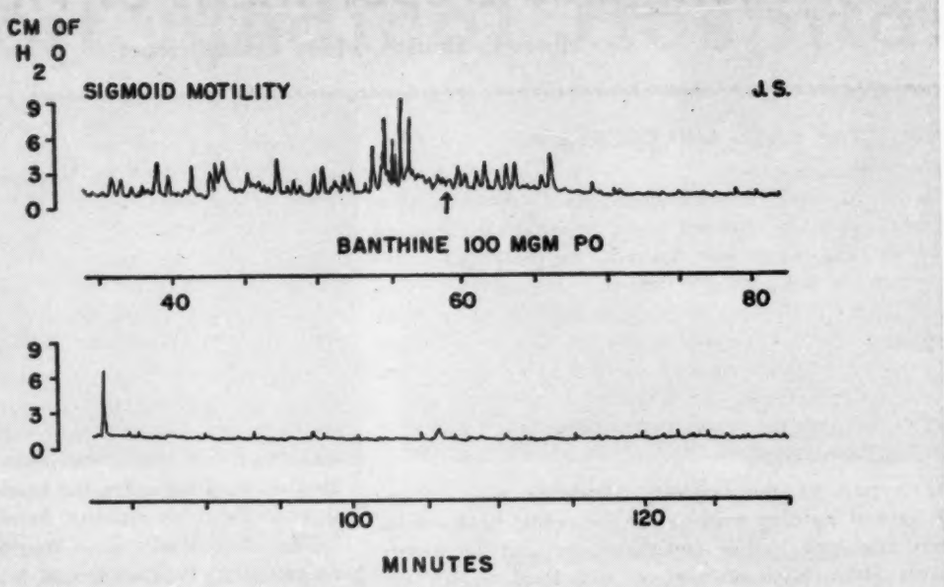
(Continued from Page 1446)

appearance of lesions during period of time covered in this report.

3. Total of twenty-six patients were treated with the ointment and ointment base, and no instances of local sensitivity were observed.

Bibliography

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice. Ed. 4, p. 709. Baltimore: The Williams and Wilkins Company, 1945.
2. Cantarow, A.: Calcium Metabolism and Calcium Therapy. Ed. 2. Philadelphia: Lea & Febiger, 1933.
3. Schoch Letter: Current News in Dermatology and Syphilology, (Nov.) 1950.
4. Tobias, N.: J. Invest. Dermat., 10:229 (Apr.) 1948.



The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.[1]

In Intestinal Hypermotility—Banthine®

"...has a prolonged inhibitory effect on human gastrointestinal motility....
The duration of its action is striking,...."[1]

It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.[2]

BANTHINE® Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.

1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β-Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), Am. J. Med. *11*:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

POLIO PEAK LATE AND DECREASE GRADUAL

The third week of September appears to have been the peak week in reported polio cases for the United States in 1952. Only four times during the past twenty-five years has the peak occurred this late, or later.

Michigan's peak week was apparently the third week of August. The decrease in reported cases following the peak was much more gradual than in previous years.

FIFTEEN PUBLIC HEALTH WORKERS ON FELLOWSHIPS

As a part of the intensive statewide plan of recruiting and training workers for the public health field, fifteen engineers, public health nurses and laboratory workers from Michigan's state and local health departments began advanced study in September on fellowships granted by the Department from federal funds allocated for that purpose.

Five engineers are attending the School of Public Health of the University of Michigan. Five public health nurses are enrolled at Wayne University and three at the University of Michigan. Two members of the staff of the laboratories of the Department are doing graduate work, one at Iowa State College and the other at Kansas University.

BIRTHS STEADILY INCREASING

Provisional statistical reports for the second quarter of 1952 show a steady increase in live births in Michigan. During the first quarter of 1952, a total of 39,530 babies arrived, 2,728 more than during the same period in 1951. For the first six months of 1952, the total was 82,287, a gain of 1,524 over the same interval in 1951.

NEW HDA SIGNS BEING POSTED

The new HDA signs marking health department approved resorts were distributed to departments in the western part of the state in time for the autumn color tours. The green and gold signs with HDA in the center oval, carrying both state and local health department approval, are replacing the black and white "Sanitation Approved" signs that have designated safe resorts for many years.

HEARING CONSERVATION PROGRAM BEGINS TENTH YEAR

With the opening of schools this fall, the department began its tenth consecutive year of co-operating with local health departments, medical societies, schools and community agencies in planning and carrying on programs to detect and facilitate correction of hearing losses in school children. So far this year, programs have been organized in twenty-five counties.

In the past nine years, over a million school children have been screened in Michigan's hearing conservation program. Thousands of them now have improved or even have normal hearing as a result of corrective measures undertaken upon discovery of hearing losses. Over 70 per cent of the children found to have hearing loss who had medical attention had their hearing improved—half of them had normal hearing restored.

Out of every hundred children tested, it has been found that three require medical attention, two need classroom adjustments to compensate for hearing loss and one needs special instruction in lip reading or to be assigned to a room for the hard-of-hearing or to go to a special school for children handicapped in hearing.

The Department now has five consultants assisting communities in conducting hearing conservation programs. Equipment is provided, in addition to consultant service.

DIRECTOR OF ENGINEERING DIVISION LEAVES STATE SERVICE

John Hepler, for twelve years Director of the Division of Engineering of the Department and for nearly thirty-four years a member of the staff of the Division, resigned on November 1, to accept assignment as Chief Sanitary Engineer at Santiago, Chile, with the Institute of Inter-American Affairs. Willard F. Shephard, Chief of the Division's Section of Sewage and Sewage Treatment, was appointed to succeed Mr. Hepler as Director of the Division. Mr. Shephard has been with the Department for thirty years.

EDWARD DUNBAR RICH SERVICE AWARDS

Awards honoring twenty-five years of service in the water works field were given to eighty-three persons at the meeting of the Michigan Section of the American Water Works Association. This brings to 800 the number of awards presented to Michigan men and women since the plan was established in 1946, commemorating the long service to the state of the late Colonel E. D. Rich.

HEALTH OFFICER CHANGES

Douglas H. Fryer, M.D., became director of the Lansing-Ingham County Health Department on October 13. Dr. Fryer was with the Bureau of Local Health Services of the Michigan Department of Health in 1944-45.

F. I. Van Waougnen, M.D., was appointed acting director of the Jackson City Health Department to serve until a full-time director is appointed.

Orlen J. Johnson, M.D., has been appointed acting director of the Bay City and Bay County Health Departments to serve until a full-time director is appointed.

Correspondence

Wilfrid Haughey, M.D., Editor
Battle Creek, Michigan

Dear Dr. Haughey:

I have been keenly interested in Blood Banks, as are all medical men, and especially those who are veterans of World War I and II. Sad to relate, the veterans themselves donate more blood than do the civilians, who seem only to pursue the almighty dollar. At least such is my experience.

Men are drafted for the army and navy. If that can be done, why not set up another corps, and draft those who are exempt from actual military service, the four Fs, et cetera, for the blood bank service, to be called when there is need. The giving of a pint of blood would be no hardship, and in no sense equal the sacrifice of being drafted.

ARCHE E. HALL, M.D., F.A.C.S.
Am.M.S., U.S.A.

To the Editor:

The American Diabetes Association offers a $250.00 prize to *medical students* and *interns* for a paper on any subject relating to diabetes. The paper can be a report of original studies, a biographical or historical note, a case report with suitable comment, or a review of the literature.

This incentive is particularly apropos in the field of diabetes, since Dr. Paul Langerhans made his studies of the pancreas, describing the islets that bear his name, while he was an undergraduate student in Berlin in 1869; and Dr. Charles H. Best, while a graduate student, was co-discoverer of insulin in 1922.

Manuscripts must be submitted on or before April 1, 1953, to the Editorial Offices of *Diabetes:* The Journal of the American Diabetes Association, 11 West 42nd Street, New York 36, New York. The papers will be reviewed by the Editorial Board, which will take into consideration the value of the material and method of presentation in selecting the best paper.

The award of $250.00 has been made possible through the generosity of the St. Louis Diabetes Association, an Affiliate of the American Diabetes Association.

Sept. 30, 1952 AMERICAN DIABETES ASSOCIATION

THE TATTERED DOLLAR

The old dollar bill, she ain't what she used to be. Showing how the dollar has declined in purchasing power, the *New York Journal of Commerce* points out that it buys only 44 cents of the 1939 value in food, 49 cents in clothing and 74 cents in rent. The manufacturer's dollar has only 40 cents of its 1939 purchasing power in labor, 43 cents in construction, and 30 cents in raw materials.

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

Arnold Wollum, M.D., and **H. Marvin Pollard, M.D.,** of Ann Arbor, are the authors of an article, "Medical Management of Chronic Ulcerative Colitis" published in the *American Practitioner Digest of Treatment,* September, 1952.

Ernest H. Watson, M.D., of Ann Arbor, is the author of an article, "Immunization of Children," which was condensed from the *Journal of the Arkansas Medical Society,* March, 1952, published in the *American Practitioner Digest of Treatment,* September, 1952.

F. Bruce Fralick, M.D., Ann Arbor, is the author of an article, "The Orbit-Annual Reviews," published in the *Archives of Ophthalmology,* September, 1952.

Laurence S. Fallis, M.D., and **James Barron, M.D.,** of Detroit, Michigan, are the authors of an article, "The Billroth I Gastrectomy," published in *The Journal of the Oklahoma State Medical Association,* September, 1952.

Laurence S. Fallis, M.D., and **James Barron, M.D.,** of Detroit are the authors of an article, "Gastric and Jejunal Alimentation With Fine Polyethylene Tubes," published in the *Archives of Surgery,* September, 1952.

J. H. Hertzler, M.D., and **William M. Tuttle, M.D.,** of Detroit are the authors of an article, "Experimental Method for an Everting End-to-End Anastomosis in the Gastrointestinal Tract," published in the *Archives of Surgery,* September, 1952.

Robert H. Clifford, M.D., of Detroit is the author of an article, "Evaluation of Three Methods for Finger Tip Injuries," published in the *Archives of Surgery,* September, 1952.

James E. Cousar III, M.D., and **Conrad R. Lam, M.D.,** of Detroit are the authors of an article, "Rectus Sheath Grafts in Vascular Repair," published in the *Archives of Surgery,* September, 1952.

J. L. Wilson, M.D., of Ann Arbor, Michigan, is the author of an article, "Relationship of Tonsillectomy to Incidence of Poliomyelitis," published in *The Journal of the American Medical Association,* October 11, 1952.

F. H. Top, M.D., of Minneapolis, Minnesota, formerly of Detroit, Michigan, is the author of an article, "Occurrence of Poliomyelitis in Relation to Tonsillectomies at Various Intervals," published in *The Journal of the American Medical Association,* October 11, 1952.

* * *

The Interstate Postgraduate Medical Association of North America met in Cleveland, Ohio, November 10, 11, 12, 13, 1952.

Cyrus G. Sturgis of Ann Arbor, President, gave an address at the Assembly dinner on "The Changing Medical Scene."

Other Michigan essayists were:

Dr. H. Marvin Pollard, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan, "Evaluation of Present-Day Treatment of Peptic Ulcer."

Dr. Fred J. Hodges, Professor of Roentgenology and Chairman of the Department of Roentgenology, University of Michigan Medical School, Ann Arbor, Michigan; Address: "Common Errors in X-ray Diagnosis."

Drs. Claire L. Straith and Richard E. Straith, Straith Clinic-Plastic Surgery, Detroit, Michigan; Address: "The Treatment of Facial Injuries and Deformities."

Dr. Cyrus C. Sturgis, Professor of Internal Medicine, Director of Simpson Memorial Institute and Chairman of the Department of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; President, Interstate Postgraduate Medical Association of North America; Clinic: "Evaluation of Some Recently Introduced Therapeutic Agents in Hematology."

Dr. Winthrop N. Davey, Assistant Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Treatment of Pulmonary Tuberculosis."

Dr. John M. Sheldon, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Place of Antihistaminics in the Treatment of Allergic Disorders."

Dr. William D. Robinson, Associate Professor of Medicine, University of Michigan Medical School, Ann Arbor, Michigan; Clinic: "Present-Day Treatment of Arthritis."

* * *

The AMA Committee on Pesticides is undertaking a toxicological study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents, and related types of chemicals used in agriculture and in the home. The committee is enlisting the aid of physicians in submitting records on fatal cases and nonfatal poisonings from pesticides. This information will be used to expand its permanent file of such cases for use by physicians and allied medical personnel. Summary data on the pertinent facts of the poisonings and the circumstances of their occurrence will be sufficient for the committee's use.

* * *

The United States Civil Service Commission has announced a Medical Officer examination for filling the positions of Rotating Intern, Psychiatric Resident, and General Practice Resident in St. Elizabeth's Hospital in Washington, D. C.

The Rotating Intern positions pay $2,800 a year,

Psychiatric Resident, $3,400 to $4,200, and General Practice Resident, $3,400 to $3,800 a year. Education and training is required. No written test will be given. The maximum age limit is thirty-five years (waived for veterans).

Full information and application forms are available at most first and second-class post offices, and at the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted until further notice by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeth's Hospital, Washington 25, D. C.

* * *

Ten Detroit Doctors have been named to a Medical Advisory Board for the new Sinai Hospital.

The Board of Trustees also announced the selection of department heads for the hospital, which is under construction on Outer Drive between Whitcomb and Lauder.

Board members are Dr. Harry Saltzstein, chief of staff; Dr. Sol. G. Meyers, vice chief of staff; Dr. I. Jerome Hauser, secretary, and Drs. Harry August, Bernard Bernbaum, Samuel Bernstein, Herbert Bloom, Saul Rosenzweig, Peter Shifrin and David J. Sandweiss.

The department heads are Dr. Saltzstein, surgery; Dr. August, psychiatry; Dr. Bernstein, pediatrics; Dr. Bernbaum, pediatrics consultant; Dr. Bloom, oral surgery; Dr. Hauser, eye, ear, nose and throat; Dr. Sidney Kobernick, director of laboratories, and Mrs. Ruth B. Edelson, director of nursing.

Dr. Julien Priver is director of Sinai Hospital, first hospital in Detroit under Jewish auspices. It is expected that the first patient will be admitted early in 1953. —*Detroit Free Press,* Oct. 2, 1952.

* * *

A. C. Furstenberg, M.D., of Ann Arbor, will be one of the lecturers of the seventh Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology at Miami Beach, January 12 to 17, 1953.

* * *

At the meeting of the Michigan Rehabilitation Conference, at Lansing, Michigan, Michigan State College, the following participated: A panel on Rehabilitation is Everybody's Business was moderated by Dr. Max Karl Newman, Detroit. The participants were James Rae, Jr., M.D., Francis Sweeney, M.D., Frederick House, M.D., and Nila Covalt, M.D. The importance of the physician, auxiliary help, vocational rehabilitation and the voluntary agencies was discussed. The date of the meeting was September 30, 1952.

* * *

Max Karl Newman, M.D., spoke at the Sixth Annual National Employ the Physically Handicapped banquet, Ypsilanti, Michigan, October 6, 1952. The topic of discussion was "The Defense Mobilization Need and the Handicapped Person."

* * *

Postgraduate Study.—The following members of the Michigan State Medical Society are now attending postgraduate courses at the Cook County Graduate School of Medicine: Milton W. White, M.D., Detroit; William L. Bird, M.D., Greenville; Arthur L. Benedict,

M.D., Muskegon; James W. Nunn, M.D., Highland Park; Lee E. Kelsey, M.D., Lakeview, and Harvey I. Kelsall, M.D., St. Joseph.

* * *

Harry F. Becker, M.D., of Battle Creek, is the new field secretary of the Michigan State Medical Society Medical Advisory Committee to the Michigan Hospital Service. **W. S. Reveno, M.D.**, is chairman. Dr. Becker served for three years on the Board of Trustees of Michigan Hospital Service, resigning to go into military service where, as a Colonel in the Medical Corps, he commanded a casualty hospital in Southern England during the invasion.

* * *

Paul de Kruif, Ph.D., Holland, Michigan (Biddle Lecturer at the 1952 MSMS Annual Session) forwarded a $100 check to MSMS President Otto O. Beck, M.D., of Birmingham for the Beaumont Memorial fund.

Dr. de Kruif is tremendously interested in the project of Michigan's doctors of medicine to build on Mackinac Island a shrine to Dr. Beaumont, one of Dr. de Kruif's "heroes."

Dr. de Kruif also forwarded a check for $100 to Earl I. Carr, M.D., President of the Michigan Foundation for Medical and Health Education, as his contribution to this fund which is aiding senior medical students, interns and residents with scholarships, to attract them to practice in rural areas of Michigan.

* * *

The American Academy of Obstetrics and Gynecology will hold its first annual clinical session at the Palmer House, Chicago, December 15-17, 1952. For program, write Ralph A. Reis, M.D., 116 S. Michigan Avenue, Chicago 3, Illinois.

* * *

The Board of Trustees of the Baraga County Memorial Hospital at L'Anse, Michigan, dedicated the new hospital at 770 North Main Street on October 12.

Congratulations and best wishes to the trustees and staff of the Baraga County Memorial Hospital!

* * *

The Board of Trustees and the Woman's Auxiliary of the United Memorial Hospital, at Greenville, dedicated their new hospital at 615 South Bauer Street on September 24.

Congratulations to the trustees, staff and Woman's Auxiliary of Greenville's new and beautiful United Memorial Hospital!

* * *

William Henry Gordon, M.D., Detroit, has been appointed a member of the Committee of the Regional Health Services Advisory Committee, Federal Civil Defense Administration. Dr. Gordon is Chairman of the MSMS Committee on Emergency Medical Service.

Congratulations, Dr. Gordon!

* * *

"SRO" was the sign that the Kellogg Center of East Lansing hung out on November 17-18! Standing room only was the experience of the late comers at the sixth annual autumn postgraduate clinic of the Wayne County and Michigan Academies of General Practice.

Reason: a wonderful and stimulating scientific pro-

gram with speakers disseminating important medical information and advice.

The chronological list of speakers included:

Joseph Meites, Ph.D., of Michigan State College; George C. Thosteson, M.D., Detroit; Sidney Friedlaender, M.D., Detroit; Duncan A. Cameron, M.D., Detroit.

G. H. Stollerman, M.D., New York City; Russell T. Costello, M.D., Detroit; R. P. Reynolds, M.D., Detroit; Robert B. Greenblatt, M.D., Atlanta, Ga.; George S. Fisher, M.D., Detroit; Lester Bauer, M.D., Detroit; J. H. Curhan, M.D., Detroit.

E. S. Beneke, Ph.D., of Michigan State College; Dan W. Myers, M.D., Detroit; Arthur E. Schiller, M.D., Detroit; Kathryn McMorrow, M.D., Detroit; Gaylord S. Bates, M.D., Detroit.

Charles E. Dutchess, M.D., New York City; E. D. Spalding, M.D., Detroit; Samuel D. Jacobson, M.D., Detroit; George J. Moriarty, M.D., Detroit.

Daniel Shaw, Jr., M.D., Philadelphia; Sibley W. Hoobler, M.D., Ann Arbor; Paul S. Barker, M.D., Ann Arbor; Lloyd T. Iseri, M.D., Detroit; Carl F. List, M.D., Grand Rapids.

The banquet was under the chairmanship of F. P. Rhoades, M.D., Detroit, with J. S. DeTar, M.D., Milan, as toastmaster. The speaker was Russell Barnes of the *Detroit News*.

This very successful conference was under the direction of E. Clarkson Long, M.D., Detroit, President of the Michigan Academy of General Practice, and John H. Schlemer, M.D., Detroit, President of the Wayne County Academy of General Practice.

The Catholic Physicians Guild of Michigan announces its autumn and winter program as follows: *November 13, 1952*—Annual Fall Meeting, David Whitney House, Detroit, Michigan. Speaker on subject of Catholic Moral Ethics, followed by afterglow, courtesy of Drug Industries through Jim Bechtel.

December 12, 13, 14, 1952—Annual Retreat at Maneresa.

March 15, 1953—Annual Mass and Communion Breakfast followed by speaker at Sacred Heart Seminary.

All Catholic out-of-state doctors of medicine are cordially invited to attend all of the above indicated meetings. For further information, write Eugene H. Quigley, M.D., Secretary, 22340 Michigan Avenue, Dearborn, Michigan.

* * *

The AMA Council on Medical Service reported at a recent meeting at AMA headquarters that mediation committees have been set up in each of the forty-eight states, the District of Columbia, and Hawaii, marking a major milestone in the medical care program for the United States.

The council also heard that voluntary health coverage continues to gain both in quality and quantity. The Council predicts that 90 million persons will be covered by some form of protection against the costs of illness, accident, and hospitalization in 1953.

Also reported was that community health councils have increased from forty-eight local health councils in 1943 to 1190 in 1951.

Approximately 600 emergency call programs are now in operation throughout the United States.

A report on physician placement services was presented to the Council by Ralph A. Johnson, M.D., Detroit, who stated that thirty-seven states have established such services.

* * *

RESOLUTION ON THE LATE A. S. BRUNK, M.D.

WHEREAS, The Conference of Presidents and other Officers of State Medical Associations suffered a great loss in the death of our friend and Executive Committee member, Andrew S. Brunk, M.D., Detroit, Michigan, and

WHEREAS, Dr. Brunk was one of the organizers and served as the first President of the Conference and was untiring in his efforts on behalf of the organization, and,

WHEREAS, Dr. Brunk was an inspiration to others and was ever willing to help in efforts to improve the science and art of medicine; therefore be it

RESOLVED, That the officers and members of the Conference of Presidents and other Officers of State Medical Associations at the annual meeting on June 8, 1952, have a deep sense of regret at this untimely loss, and be it further

RESOLVED, That a copy of this resolution be spread upon the records as a token of esteem to the memory of Andrew S. Brunk, M.D., and be it further

RESOLVED, That a copy of this resolution be transmitted to his family with the sincere sympathy of the Conference of Presidents and other Officers of State Medical Associations.

Adopted by the Conference of Presidents and Other Officers of State Medical Associations, June 8, 1952.

* * *

The AMA Board of Trustees has reiterated its previous stand that doctors everywhere should take a more active interest in the affairs of the American Legion. Physicians who are members of the Legion were urged specifically to attend meetings of their posts since the policies of the Legion, like those of the AMA, are decided at the grass roots level.

The Board's expression came after it had studied a report on health matters which were discussed at the Legion convention in New York a short time ago.

Legion delegates adopted a resolution opposing ILO procedures that would socialize medicine by international treaty, and they turned down another resolution which would have mandated the Legion to urge the Veterans Administration to give special recognition to chiropractors. This would have permitted veterans to choose chiropractic treatment at government expense. A similar resolution for optometry was also defeated. The chiropractor resolution, coming from eight state departments of the Legion, resulted in one of the bitterest battles on the floor of the convention. The fact that it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.—ORLANDO F. HULL, M.D., Secretary's Letter, September 24, 1952.

* * *

Louis P. Groos, M.D., of Escanaba, is the new President of the Upper Peninsula Medical Society. The

Secretary is N. L. Lindquist, M.D., of Escanaba. Congratulations, Doctors Groos and Lindquist!

The 1953 U.P. meeting will be held next July in Escanaba.

* * *

The "ubiquitous hosts" at the State Society meeting were observed hurrying and scurrying hither and thither trying to catch up with the guest essayists. In case you don't know what an ubiquitous host is—it's a person designated by the State Society to meet all trains, planes, buses, streetcars and trailers—to look for an academic phantom orator and otherwise to apprehend a stranger in town who always carries a briefcase, wears glasses, baggy pants—and otherwise might be mistaken for a doctor—or as they are so whimsically referred to—as guest essayists.

This phantom figure, called a guest essayist, is usually brought under scrutiny by the ubiquitous host at an airport or railroad station where the essayist is observed walking in circles looking for the ubiquitous host, or the powder room, or the barber shop, or a place to mail postcards. The ubiquitous host has only the faintest idea what the man looks like but he has been told to get his man—and escort him to the hotel—and if necessary show the dazed, wandering essayist to his hotel room—in case he has one.

After the ubiquitous host has expressed his regrets to the ubiquitous guest for his tardiness at the station, he leaves the essayist to himself in solitary confinement in his hotel room—to freshen up a bit—and also to allow the essayist to spend some time in front of the mirror practicing the speech he is about to present to the academic assembly.

The guest essayist finally gives his speech, during a lull when one of the slides is inserted upside down and the lights are out, and the ubiquitous host puts on the disappearing act—because he also must freshen up a bit, you know. By the time the ubiquitous host returns to the ubiquitous hall the ubiquitous essayist has already finished his talk—and the entire assembly is out viewing the exhibits and filling their pockets with samples—so the ubiquitous host scampers into the noisy current of human traffic trying again to find his man—but he has already absconded.

To be a good efficient ubiquitous host you must be tolerant, kind, patient and courageous—and not umbrageous.—JJL, "Rant and Rave," *Detroit Medical News,* Oct. 6, 1952.

* * *

The International Academy of Proctology announces its award contest for 1952-53 for the best unpublished contribution on proctology or allied subjects. For information write the Academy at 43-55 Kissena Blvd., Flushing 55, N. Y.

* * *

Clarence Manion, LL.B., MSMS Biddle Lecturer of 1951, announces his association with the legal firm of Doran & Manion in South Bend, Indiana. Dr. Manion recently resigned as Dean of the College of Law of the University of Notre Dame.

* * *

Thirteen laboratory refresher courses covering the serology of syphilis and the laboratory diagnosis of

venereal disease were recently announced by Theodore J. Bauer, M.D., Chief of the Public Health Services, Division of Venereal Disease, Washington, D. C. The courses, to be conducted at the Venereal Disease Research Laboratory in Chamblee, Georgia, begin in January, 1953, and are open to senior technicians and to laboratory directors throughout the United States. For further information on these courses that run from January 12 through December 18, contact Dr. Bauer, Box 185, Chamblee, Georgia.

* * *

The Michigan State Medical Assistants Society elected at its September, 1952, convention in Detroit the following officers: President, Cary Guthaus, Bay City; President-Elect, Elizabeth Peck, Detroit; Recording Secretary, Noreen Nuechterlein, Saginaw; Corresponding Secretary, Margaret Schultz, 1110 David Broderick Tower, Detroit 26; Treasurer, Marion Horning, Grand Rapids.

* * *

James L. Wilson, M.D., Ann Arbor, is the author of an original article "Relationship of Tonsillectomy to Incidence of Poliomyelitis" which appeared in JAMA of October 11, 1952.

* * *

The Michigan Supreme Court ruled on September 5, 1952, that the 1951 charter amendment permitting osteopaths and dentists to sit on the Bay City's Board of Health was null and void.

The Supreme Court's decision stemmed from the fact that the charter amendment was submitted at the February primary of 1951, contrary to State law requiring that such proposals submitted by initiatory petitions be voted upon only at regular municipal or state elections.

* * *

"An Assignment to India" was the subject of a talk by Abraham Stone, M.D., Vice President of Planned Parenthood Federation of America, Inc. at the 21st Annual Meeting of the Michigan League for Planned Parenthood, in Ann Arbor, on October 21.

Palmer E. Sutton, M.D., Royal Oak, is Chairman of the Medical Advisory Committee of the Michigan League.

* * *

Herman F. Albrecht, M.D., Detroit, recently announced that he has retired and closed his office at 2686 West Grand Blvd. in Detroit, as of October 15, 1952.

* * *

The Wayne County Medical Society Council, at its meeting of October 3 in Detroit, voted to establish a Telephone Message Exchange. This Exchange will be inaugurated with an initial roster of 300 members.

Congratulations, practitioners of Wayne County!

* * *

An interesting article, "Doctors are Generous Givers," appeared simultaneously in the June issue of *Modern Hospital* and the June issue of *Medical Economics.* The article, written by George Radcliffe, Senior Campaign Director, Ketchum Inc., Pittsburgh, indicates that contrary to the opinion of many, figures on more than 1,000

hospital campaigns in 245 United States cities in the last thirty-three years reveal that the highest per capita contributions came from the doctors on their staffs. The recent survey of six major hospital campaigns shows that $928,661 was contributed by only 601 doctors. Analyzing these 6 appeals it was found that the doctors had contributed almost 8 per cent of the total. The average gift was $1,545.

* * *

The United Cerebral Palsy Association is widening the scope of research into more of the mysteries surrounding cerebral palsy through seven new research and training grants totalling $23,350. In addition, $66,922 have been allocated for renewal of previously authorized grants for research or the training of skilled personnel; two new grants for $19,423 for training of personnel also were approved, according to an announcement by Charles F. McKhann, M.D. of Philadelphia, National Medical Director for United Cerebral Palsy.

James L. Wilson, M.D., of Ann Arbor, is vice chairman of the UCP's Medical Executive Board.

One of the grants in the amount of $2,000 was given Richard J. Allen, M.D., of Ann Arbor, on the subject: "Basic neurology with view to a career in academic medicine with special interest to brain-damaged children."

* * *

The National Foundation for Infantile Paralysis announces the availability of a limited number of additional postdoctoral fellowships to candidates whose interests are research and teaching in medicine and the related biological and physical sciences. The fellowships cover a period of from one to five years and range from $3,600-$7,000 a year. For full information write: Division of Professional Education, N.F.I.P., 120 Broadway, New York 5, N. Y.

A new MSMS rheumatic fever control center has been opened in Sault Ste. Marie to serve the medical profession and public of Chippewa, Luce, Schoolcraft and Mackinac Counties.

Following the Fourth Michigan Heart Day Program of the Michigan Clinical Institute on Friday, March 13, 1953, the annual meeting of members of the Michigan Heart Association will be held at 5:00 P.M. at the Sheraton-Cadillac Hotel. The Michigan Heart Association Board of Trustees meeting will follow.

* * *

This story was told by one of our nurses, who was privileged to witness it. It happened in a nearby city The surgeon was overworked, consequently irritable and often profane. An emergency had played havoc with the doctor's schedule. The atmosphere in the operating room reflected the doctor's tension and irritability. The anesthetist murmured assuringly to the dainty young woman on the operating table. "Breathe naturally and count slowly." She wondered if the lovely girl, so relaxed and smiling knew what a serious operation she was facing. "I would rather say the Twenty-Third Psalm, if you do not object." The doctor's face reflected surprise and sudden interest. "Yes, say it. I need to hear the Twenty-Third Psalm this morning, too." The quiet of the operating room was broken only by the confident voice of the girl. "The Lord is my Shepherd, I shall not want." Peace and serenity had suddenly filled the operating room. In that strange setting, nurses and the doctor listened to the simple beauty of that glorious old Psalm as if they had never heard it before. "Yea, tho I walk thru the Valley of The Shadow of Death, I will fear no evil, for thou art with me. Thy rod and Thy staff, they comfort me." Her voice was growing softer; she spoke more slowly. "Hold it," the doctor said to the anesthetist, "I want to hear all of it." "Surely, goodness and mercy shall follow me all the days—of—my — life." Her voice trailed off and then all was still. Misty eyed but apparently refreshed in spirit, the doctor nodded and the operating room sprung into action. The patients, who are admitted to the hospital, need not only skilled medical and surgical care but frequently psychiatric understanding. The doctor who allowed the little patient to repeat the Twenty-Third Psalm, instead of just counting, sent his patient into the etherized unknown, calm, serene and comforted.—*Michigan Hospital Association News,* October, 1952.

* * *

OLDSTERS TAKE NOTICE

Vanderbilt at eighty added more than a hundred million to his fortune. Wadsworth earned the Laureateship at seventy-three. Thiers at seventy-three established the French Republic and became the first president. Verdi wrote "Falstaff" at eighty. Gladstone became Premier of England for the fourth time at eighty-three. Stradivarius made his first violin after sixty. And Sir Walter Scott was $600,000 in debt at fifty-five, but through his own efforts paid this amount in full and built a lasting name for himself.—*Capital Cogs,* Albany.

In Memoriam

Charles R. Walsh, M.D., of Detroit, died September 8, 1952, at the age of sixty-five.

Dr. Walsh had practiced medicine in Detroit for forty years before giving up his practice four years ago because of failing health. He was graduated from the University of Louisville School of Medicine in 1908 and interned at Grace Hospital, Detroit, in 1910. He was on the staff of Grace Hospital for many years.

Dr. Walsh is survived by his wife, Florence; his father, Patrick J. Walsh, of Detroit; two sisters, Mrs. C. A. Ellington, of Lake Orion, and Mrs. W. J. Ferguson, of Miami, Florida.

THE USE OF AN ANTISEPTIC SYNTHETIC DETERGENT FOR LOCAL HYGIENE IN PRURITUS ANI

(Continued from Page 1448)

tients have so uniformly appreciated the feeling of cleanliness and the early relief which they have obtained, that the method deserves a wider trial.

Conclusions

1. Proper local hygiene is an important therapeutic aid in the treatment of pruritus ani.

2. PHisoderm with hexachlorophene, 3%, (pHisoHex®), a commonly used surgical scrubbing agent, is an effective and practical preparation for this purpose.

3. The results of a seven months trial period in forty-five cases have indicated that the method described is a useful adjunct in the therapy of this annoying condition.

References

1. Kallet, Herbert I.: The clover leaf operation for pruritus ani. Trans. Am. Proc. Soc., p. 240, 1946.
2. Chisholm, T. C., Duncan, T. L., Hufnagel, C. A., and Walter, C. W.: Disinfecting action of pHisoderm containing three per cent hexachlorophene on the skin of the hands. Surgery, 28:812 (Nov.) 1950.
3. Freeman, B. S., and Young, T. K. L.: Clinical studies of the use of a synthetic detergent combining 2,2-dihydroxy-3,5,6-3′,5′6′hexachlorodiphenylmethane ("G-11") for disinfection of the skin. Surgery, 25:897 (June) 1949.
4. Guild, B. T.: Cutaneous detergents. Arch. Dermat. & Syph., 51:391 (June) 1945.

944 Maccabees Building

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Associate Clinical Professor of Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis State Hospital; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology; Visiting Physician in the Department of Dermatology at the St. Louis City Hospital. Fourth Edition. Illustrated. Philadelphia: J. B. Lippincott Co., 1952. Price $6.00.

In this fourth edition of Essentials of Dermatology, Tobias has revised his book to include recent discoveries in etiology and advancements in therapy up to 1952. Some of the newer knowledge in virus cutaneous diseases is included. The discussion of each of the many skin diseases is outlined as to clinical description, etiology, pathology, differential diagnosis, prognosis, treatment, et cetera. This makes for easier reading and study by students. The compactness makes it a valuable book. While details could not be included in a book of this type, all important items are. While not a reference book for Dermatologists, this book is very good for medical students and general practitioners. It contains, as the title indicates, the essentials of Dermatology.

H. E. A.

A METHOD OF ANATOMY, Descriptive and Deductive. By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.) Professor of Anatomy, University of Toronto. Fifth Edition. Baltimore: The Williams & Wilkins Co., 1952. Price $7.00.

This book endeavors to leave less to the effort of memory and more to the underlying principles of anatomy so that the readers will learn to reason anatomically. It is reminiscent of an old Gray's anatomy of the last century, where only the arteries and veins were colored, except in this instance there is no color at all in the drawings; and despite the fact that the schematic and diagramatic illustrations are excellent, the absence of color lessens the value of the work. The absence of color is very noticeable in those diagrams where bone and muscle are portrayed, and it is particularly difficult to gain a good idea of the abdominal viscera without color. Portions of the book have excellent phraseology, while other parts are terse and uneven, and the meaning is not quite as clear as it might be. The explanation of the mechanics of bone and muscle is excellent and should make the text appeal to all those interested in orthopedics. The description of the result and the traumatic sequence of various types of falls is also very good. Descriptions such as: "The clavicle is a strut that forces the scapula laterally and backwards," make the text interesting as well as the inclusion of various anatomical anomalies, particularly those of the kidneys, ureters, bile ducts, nerves and ribs. X-rays also add to the text, and a chapter on advice to the dissector following the preface is good.

Unfortunately, certain terms are used apparently in

an effort to attain simplicity, an example being that the apocrine glands are not mentioned as such, but are called "disintegrating sweat glands," or "sexual skin glands." It goes into considerable detail about the growth of the nails but completely fails to mention the neuromyoarterial glomus of the skin, although it describes its function. It enters into the physiological background of anatomy, which in most texts is not included, but here one wonders whether it should have been included, a particularly egregious example being the description of adrenal function.

Serious errors are present, such as assigning a life span of only six weeks to an erythrocyte. The author points out that he is ignoring topographical anatomy but, unintentionally, he also covers visceral anatomy and neurology very sketchily. The author is possessed of a wide and varied knowledge, this being particularly emphasized in the dissertation on the animal experimentation concerning the thoracic duct. The book is recommended as an ancillary text to those having another anatomy in their libraries. The book must be of some value since it has gone to five editions and eleven reprints. Its low price also recommends it.

A.A.H.

THE TREATMENT OF INJURIES TO THE NERVOUS SYSTEM. By Donald Munro, M.D., F.A.C.S., Surgeon-in-Chief, Department of Neurosurgery, Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine; Assistant Professor of Neurosurgery, Harvard University Medical School. Illustrated, Philadelphia: W. B. Saunders Co., 1952. Price $7.50.

The author states that this book was primarily written for the general surgeon and general practitioner. Due to the numerous motor and other accidents of which many casualties involve a part of the nervous system this small volume appears timely and needed. The writer is gifted. He can adequately describe and inform without the use of unnecessary words. There is no theorizing or inconclusive advice. He presents his methods in a straightforward manner. He has been able to cover the entire gamut of diagnosis and therapy from the proper way to transport spinal cord injury cases to rehabilitation. The care of the genito-urinary tract includes tidal drainage, cystometry and bladder training. There are chapters on prevention and the overcoming of contractures. There is a listing of minimal instrumental and other equipment and operative procedures. To complete the book more fully there are forty-seven illustrations and nine tables for differential diagnostic and comparative purposes.

G.K.S.

LIVING WITH CANCER. By Edna Kaehele. New York: Doubleday & Co., Inc., 1952. Price $2.00.

An inspiring true story of a woman given six months to live who courageously decided to "outgrow" her cancer. She is alive and leading a full and busy life six years later, although she still has an active malignancy.

Mrs. Kaehele (rhymes with Bailey) writes principally for those who also have cancer. Suffering from a rapidly growing malignancy, she was treated with x-ray therapy, radium, gold seeds and radium chloride. At the

end of these treatments she weighed 90 pounds and no hope was held for her recovery. Because her family would not give up, and because she decided she was "more important than any growth occupying her body," she feels she continued to live. She suggests that those with cancer "search out the best cancer specialist you can find and make full use of the most advanced resources available. But do it hopefully, not fearfully. If at the end you come to the day when all has been done that can be done medically and you still have a cancer, do not be discouraged. Remember that while compromise may not be as good as victory, it is incomparably better than defeat. You may not be able to cure it, but you can *live* with cancer."

Any doctor who diagnoses or treats cancer could benefit by reading this book. He may not agree with all she says, but he will find her remarkably sensitive subjective approach illuminates the psychology of the patient, and in addition tells a readable human story. Most of his patients could take heart from this book and their families and friends would find it inspirational.

J.A.H.

THE LOW FAT DIET COOK BOOK. By Dorothy Myers Hildreth and Eugene A. Hildreth, M.D. Introduction by Francis C. Wood, M.D. Distributed by Grosset and Dunlap, New York: Medical Research Press, 1952. Price $2.95.

Mrs. Hildreth, consultant dietitian for the University of Pennsylvania Robinette Foundation, Heart Clinic, participated in research on the low fat diet with her husband, Dr. Eugene Hildreth, also associated with the University of Pennsylvania and a Fellow of the United States Public Health Service. Between them they have impressive experience to write this authoritative book.

Their cook book contains low fat (between 25 and 35 grams of fat daily) menus for a week, and over 200 recipes showing ways to cook appetizing low fat dishes. Included is information on the grams of fat per serving of all types of food, suggestions on menu planning, and a list of foods to be avoided. The Hildreths actually lived on this diet for some weeks, so the menus and recipes have authenticity.

This book could be very helpful to patients on a low fat diet. The recipes for low fat gravy and mayonnaise, and the many other practical suggestions, should make a real difference in mealtime pleasure for the patient with arteriosclerosis.

J.A.H.

POISONING—A GUIDE TO CLINICAL DIAGNOSIS AND TREATMENT. By W. F. von Oettingen, M.D., Ph.D., National Institutes of Health, U. S. Public Health Service, Federal Security Agency, Bethesda, Md. New York: Paul B. Hoeber, Inc. (Medical Book Department of Harper & Brothers) 1952. Price $10.00.

This book, by a most eminent authority, fills a very specific gap in today's clinical literature. Here is a comprehensive reference guide that will help the practicing physician quickly detect poisoning and institute effective treatment.

One section is devoted to signs and symptoms and they are classified by body systems and discussed one by one as they present themselves in the course of a clinical examination. Here we will look first, for under each sign or symptom we will find a list of toxicants which may be responsible for the change we have observed.

Next, there is the management of the case, including the rationale of treatment, the removal of the toxic agent, the elimination of the toxic agent, the detoxification of the absorbed poison, the symptomatic treatment, and lastly the general measures and treatment of the after-effects.

The final section, and the largest, offers an alphabetical index of the symptoms and treatment of the 461 types of poisoning. This is truly a comprehensive and worthwhile compilation of information and every physician should have it readily available.

G.W.S.

Permanent cancer cures are still achieved largely with surgery and/or external irradiation administered to patients with early lesions that have not yet metastasized widely.

* * *

The fact that cancer cells, like bacteria, are capable of developing resistance to therapeutic agents, accounts for the many failures in the drug therapy of cancer.

* * *

In the current preoccupation with specific therapy, sight is often lost of the fact that the patient as well as the cancer must be treated.

OFFICE TREATMENT OF THE UROLOGICAL PATIENT

(Continued from Page 1436)

slide). Large calibre urethral strictures, No. 20-24 French, are frequent in the female and a common source of urinary complaints and infections, and may indeed cause abdominal or lumbar pain. Treatment by dilation with a Walther sound is usually very beneficial. It should be repeated once a week until No. 26-30 French is acquired and then the interval may be lengthened up to as long as six months. An instillation of Argyrol or weak silver nitrate (¼ per cent) is usually beneficial as an adjunct to the sound.

Summary

Office treatment of the urological patient includes a careful history, a discerning examination, and gentleness in the instrumentation of the genito-urinary tract. Important in the history are sex, age, marital status, description of the urinary complaints, past history, sexual habits, eating and drinking habits. Physical examination should include a general appraisal of the patient as well as an exacting record of the findings in the genito-urinary tract. Treatment is local and general in type, with an increased armamentarium of drugs that demands careful selection for their most efficient use.

Bibliography

1. Campbell, Meredith: Clinical Pediatric Urology. Philadelphia: W. B. Saunders Company, 1951.
2. Hess, Elmer; Roth, R. B., and Kaminsky, A. F.: The general practitioner as urologist. J.A.M.A., 144:601 (Oct. 21) 1950.
3. Jawetz, E.; Gunnison, J. B., and Speck, R. S.: Antibiotic synergism and antagonism. New England J. Med., 245: No. 25 (Dec. 20) 1951.
4. Nesbit, Reed M.: Postgrad. Med., 4:111, 1948.